045003 FEB 2 7

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05278
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ELEANOR M. ADAMS

2a. DATE OF DEATH MONTH DAY YEAR: February 13, 1987

2b. HOUR: 1:35 P.M.

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: February 16, 1890

6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 301 Russell Avenue 20877

14. FATHER'S NAME FIRST MIDDLE LAST: George Marshall

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Maria Macpherson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 577-05-6651

17. INFORMANT: Daughter ADDRESS: 709 E. Franklin Ave. Eleanor A. Dickmann Silver Spring, Md. 20901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral Arteriosclerosis	4 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-12 19 84 to 2-13 19 87 that (I) (we) last saw the deceased alive on 2-13 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-13-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr. MD

22e. ADDRESS: 207 Brookes Ave Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 16, 1987

23c. NAME OF CEMETERY OR CREMATORY: Congressional

23d. LOCATION CITY OR TOWN COUNTY STATE: Washington, D. C.

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd., W. Silver Spring, Md.

25a. DATE REC'D BY REGISTRAR: FEB 20 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual death, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

046287 MAR 10

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05279
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST George MIDDLE H. LAST Adams

2a. DATE OF DEATH: MONTH 2 DAY 28 YEAR 87

2b. HOUR 7:45 A.M.

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 10 DAY 4 YEAR 24

6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mapping Librarian

12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Def.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Wheaton

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 12311 Bushey Drive 20906

14. FATHER'S NAME: FIRST William MIDDLE F. LAST Adams

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE E. LAST Neill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes

(IF YES, GIVE WAR OR DATES): W.W. II

16b. SOCIAL SECURITY NO.: 224-26-9319

17. INFORMANT: Alice J. Adams wife ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic adenocarcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive lung disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/19 1987 to 2/28 1987, that (I) (we) last saw the deceased alive on 2/28 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.

22b. SIGNATURE: B.N. Rosenbaum, M.D. DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): B.N. ROSENBAUM

22e. ADDRESS: 3720 FARRAGOT AVE. KENSINGTON, MD. 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: March 3, 87

23c. NAME OF CEMETERY OR CREMATORY: Md. Veterans Cemetery

23d. LOCATION: CITY OR TOWN Cheltenham COUNTY Prince Georges STATE Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: MAR 06 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place page 3 above carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045938 MAR -4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place page 4 with carbon papers, Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR STATE REGISTRAR 1.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 005280

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: L. LAST: Alderton		2a. DATE OF DEATH MONTH DAY YEAR: 2-25-87	2b. HOUR: 9:45 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Mar. 19, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Oldtown	YES ☐ NO ☒	Rural / 21555

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Alfred / Shryock	Geneva / Athey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-52-5426	Elmo C. Alderton	Silver Spring, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis	11 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral Arteriosclerosis	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 19 81, to Feb 25, 19 87, that (I) (we) last saw the deceased alive on Feb 20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James R. Moore	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-25-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James R. Moore Jr.	207 Brookes Ave Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 28, 1987	Shryock Ceme.	Town Creek, Allegany, MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	REGISTRAR'S SIGNATURE
John J. Hafer, Jr.	LaVale, MD	MAR 02 1987	Julia Davidson-Randall

4720 FEB 20 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05281
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances MIDDLE: Newhart LAST: Algren
FRANCES Newhart algren

2a. DATE OF DEATH MONTH DAY YEAR: 2 14 '87
2b. HOUR: 6a M

3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH MONTH DAY YEAR: 1 13 '11
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife.
12b. KIND OF BUSINESS OR INDUSTRY: Own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 809 Kenbrook Drive / 20902

14. FATHER'S NAME FIRST: Frank MIDDLE: LAST: Newhart
15. MOTHER'S MAIDEN NAME FIRST: Myrtle MIDDLE: LAST: Reynolds

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 072-03-0624
17. INFORMANT: Oliver G. Algren, ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Pleural Effusion — 1 mo
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Breast — 15 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 87, to 2/14 19 87, that (I) (we) last saw the deceased alive on 2/13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E. Lejm DEGREE: M.D ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDGAR H. LEJM
22e. ADDRESS: 9801 Georgia Ave, Silver Spring, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 2-14-87
23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory
23d. LOCATION CITY OR TOWN COUNTY STATE: Alexandria, Virginia

24. FUNERAL DIRECTOR NAME: Richard Rapp, Inc. ADDRESS: 1804 T Street, NW, Washington, DC 20009
25a. DATE REC'D. BY REGISTRAR: FEB 19 1987
25b. REGISTRAR'S SIGNATURE: Julia Hoidson-Rundess

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05282

45658 MAR -2 87

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ghulam MIDDLE: LAST: Alvi
2a. DATE OF DEATH — MONTH DAY YEAR: 2-25-87
2b. HOUR: 1855 M
3. SEX: Male
4. RACE: Pakistani
5. DATE OF BIRTH — MONTH DAY YEAR: March 16, 1942
6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pakistan
7b. CITIZEN OF WHAT COUNTRY?: Pakistan
8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher
12b. KIND OF BUSINESS OR INDUSTRY: Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 201 North Adams Street/20850

14. FATHER'S NAME — FIRST: Ellahi MIDDLE: Bukhesh LAST: Awan
15. MOTHER'S MAIDEN NAME — FIRST: Sardar MIDDLE: LAST: Beghum
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 217-94-5365
17. INFORMANT: Ghulam Awan — ADDRESS: 1920 S Street NW Washington, D.C. 20009

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock — 30 hours
DUE TO, OR AS A CONSEQUENCE OF (c) Immunosuppression — 1½ years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Transplant on Immunosuppression

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [✓]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7 July, 19 86, to Feb 25, 19 87, that (I) (we) last saw the deceased alive on Feb 25, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Alison Notts — DEGREE: ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2-26-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Alison Notts
22e. ADDRESS: 14915 Broschart Rd Suite 102 Rockville MD 20853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial/Transit
23b. DATE: Mar. 3, 1987
23c. NAME OF CEMETERY OR CREMATORY: Kot Shah Mohd
23d. LOCATION — CITY OR TOWN COUNTY STATE: Dist;Gujranwald,Punjab,Pakistan
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home, /Rockville. 300 W. Montgomery Ave. Rockville, Maryland 20850
25a. DATE REC'D. BY REGISTRAR: FEB 27 1987
25b. REGISTRAR'S SIGNATURE: Julia Bandon-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cremation pouches. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an death trauma, in event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 4/82 (VRA 15, 4)

043884 FEB 13 97

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05283

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner notified and Approved Dr. Maley

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the death referred to the medical examiner. The law requires that the death be reported within 24 hours after death. Page 4 may be executed within 24 hours after death.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Blanka MIDDLE: Elizabeth LAST: Amundson			2a. DATE OF DEATH MONTH DAY YEAR: Feb. 9TH 1987	2b. HOUR: 1250 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 3 1919	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 21 Philadelphia Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): World Wide Films	12b. KIND OF BUSINESS OR INDUSTRY: President

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Mont	Takoma Park	YES [X] NO [ ]	21 Philadelphia Avenue 20912

14. FATHER'S NAME FIRST / MIDDLE / LAST: Hans Groeger		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Deordina L. Hirsche	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N A	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 085 28 9985	17. INFORMANT ADDRESS: Orville Amundson (Husband) Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY	2 DAYS
	DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF UNKNOWN PRIMARY	6 MONTHS
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 14 AUG, 19 86, to 7 JAN, 19 87, that (I) (we) last saw the deceased alive on 7 JAN, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James J. Perry MD CPT MC	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 9 FEB 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. James J. Perry	22e. ADDRESS: Walter Reed Medical Center, Wash. D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/9/87	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alex. Va.
24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR: FEB 11 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

043811 FEB 1 87

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05284
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Robert B Anderson		2a. DATE OF DEATH MONTH DAY YEAR: 02-06-87	2b. HOUR: 6:18 AM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: May 16 1906	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Foreman	12b. KIND OF BUSINESS OR INDUSTRY: Manufacturing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Chevy Chase	YES ☐ NO ☐	4111 Aspen St. 20815

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Marley Anderson	Viola S. DeLano

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		308-09-6721 A	Robert L. Anderson	1500 W. Havens St, Ind.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 7, 1983, to present 19____, that (I) (we) last saw the deceased alive on 2/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
J. B. Umhau	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John B Umhau MD		22e. ADDRESS: 8805 Conn. Ave. Chevy Chase, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb 11.87	MIDWEST CREMATORY	Indianapolis Ind

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives Pearson Funeral Homes, Arlington, Virginia 22201	FEB 9 1987	[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84 (VRA 15, 4)

045732 MAR -3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05285
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: William L. Anderson

2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1987

2b. HOUR: 2:00 a.m.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: 7/07/05

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor

12b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 13810 Congress Drive 20853

14. FATHER'S NAME FIRST MIDDLE LAST: William E. Anderson

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mattie E. Lamb

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-01-9133

17. INFORMANT: Carolyn L. Anderson Wife

ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PERITONITIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one week

DUE TO, OR AS A CONSEQUENCE OF

(b) Perforated carcinoma, cecum — one week

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [✓] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [✓] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/12 19 87 to 2/19 19 87 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Julian T Coggin MD

DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: Feb 20, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Julian T Coggin

22e. ADDRESS: Pathology Dep Montgomery Gen Hosp Olney, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23, 1987

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Brentwood Pr. Geo. Maryland

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr.

ADDRESS: 500 University Blvd., W. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045611 FEB 27 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05286
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Claire MIDDLE: LAST: Ash

2a. DATE OF DEATH MONTH DAY YEAR: 2/23/87

2b. HOUR: 6:00 AM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: 8/7/99

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Ctr.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary (Ret.)

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY: --------

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 4000 Mass.Ave.,N.W.,#1515 (20016)

14. FATHER'S NAME FIRST: Morris MIDDLE: LAST: Bleetstein

15. MOTHER'S MAIDEN NAME FIRST: Gussie MIDDLE: LAST: Elchones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): ---------

16b. SOCIAL SECURITY NO.: 578-22-2537

17. INFORMANT (NAME, RELATIONSHIP, ADDRESS): Janice Berger;Niece;5006 McCall Street; Rockville, Md. 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Metastatic Breast Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Emphesema

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug, 19 85, to Feb 23, 19 87, that (I) (we) last saw the deceased alive on Feb 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gary H. Miller MD

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. 24, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GARY H. MILLER, M.D.

22e. ADDRESS: 916 19th Street, N.W.,Suite,#624;Wash.,D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/25/87

23c. NAME OF CEMETERY OR CREMATORY: King David Mem.Garden

23d. LOCATION CITY OR TOWN COUNTY STATE: Falls Church;Fairfax;Virginia

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requ[illegible] death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been [illegible] attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. The [illegible] carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene [illegible] or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 999999

DHMH - 16 60M 7/84 (VRA 15, 4)

044639 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 81
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy MIDDLE: G. LAST: Aspelmier

2a. DATE OF DEATH MONTH DAY YEAR: 2 / 16 / 87

2b. HOUR: 1:50 PM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: 9 / 14 / 1901

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Oklahoma

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Damascus

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 9305 Gue Road 20872

14. FATHER'S NAME FIRST: Vernon MIDDLE: H. LAST: Gee

15. MOTHER'S MAIDEN NAME FIRST: Delle MIDDLE: LAST: Yocom

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 521-42-3996

17. INFORMANT: Vernon Hogg ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PROGRESSION of Advanced Parkinson's Dis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Chronic
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2 Nov, 19 86, to Feb 16, 19 87, that (I) (~~we~~) last saw the deceased alive on 14 Feb, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: RE Dooley, MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: FEB 16, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas E. Dooley, MD

22e. ADDRESS: 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/16/87

23c. NAME OF CEMETERY OR CREMATORY: Westview Mem. Pk.

23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Md. STATE:

24. FUNERAL DIRECTOR NAME ADDRESS: Olin L. Molesworth, P.A., Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please file pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

043271 FEB -9 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyg are prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05288
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CATHERINE C BALDWIN		2a. DATE OF DEATH MONTH DAY YEAR: 02 01 1987	2b. HOUR: 2:56pm
3. SEX: FEMALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 25 1909	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Defense

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Prince Georges	Hyattsville	YES ☒ NO ☐	6700 Belcrest Rd. #1020 20782

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Joseph Lee	Catherine Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		578-20-7321	son Thomas Baldwin	4001 Kennedy Street, Hyattsville, Md. 20781

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION, LOW CARDIAC

DUE TO, OR AS A CONSEQUENCE OF (c) OUTPUT, ACIDOSIS, RENAL

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): FAILURE & PULMONARY INSUFFICIENCY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/13/87	MITRAL VALVE REGURGITATION. CHF	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 87, to 2/1, 19 87, that (I) (we) last saw the deceased alive on 2/1/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not view) the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
S. Nemat MD	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SAMIR NEMAT, MD.	10313 GEORGIA AV SILVER SPRING, MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 4, 1987	Ft. Lincoln Cemetery	Brentwood Prince Georges Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis J. Collins, Jr.	500 University Blvd. West, Silver Spring, Md.	FEB 6 - 1987	Julia Fridson-Tolnay

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 / 052 89

044761 FEB 20

1. DECEASED NAME (TYPE OR PRINT): FIRST Charles MIDDLE R LAST Ball

2a. DATE OF DEATH: MONTH 2 DAY 13 YEAR 87

2b. HOUR: 6:25 PM

3. SEX: M

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 4 DAY 02 YEAR 22

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Fireman

12b. KIND OF BUSINESS OR INDUSTRY: D.C. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 10008 Raynor Road 20901

14. FATHER'S NAME: FIRST William MIDDLE Clifford LAST Ball

15. MOTHER'S MAIDEN NAME: FIRST Edith MIDDLE LAST Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): W.W. II

16b. SOCIAL SECURITY NO.: 579-16-5553

17. INFORMANT: Mary Frances Ball ADDRESS: wife same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MASSIVE Pulmonary Embolus — 30 minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Obstructive Pulmonary Disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bleeding Erosive Esophagitis

19a. DATE OF OPERATION: 0

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6, 1987, to 2/13, 1987, that (I) (we) last saw the deceased alive on 2/13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan Weinstock MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN WEINSTOCK MD

22e. ADDRESS: 10313 Georgia Ave Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 18, 1987

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION: CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS ~~500 University Blvd. West, Silver Spring, Md.~~

25a. DATE REC'D. BY REGISTRAR: FEB 19 1987

25b. REGISTRAR'S SIGNATURE: Julia Christian Andrews

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

Item # 13e,14 & 15 Film G 625 3/13/87 ra

045147 FEB 16 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 90
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ILONA MIDDLE: LAST: BAN

2a. DATE OF DEATH MONTH DAY YEAR: 02 2087

2b. HOUR: 2050

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: March 12 1912

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hungary

7b. CITIZEN OF WHAT COUNTRY?: USA.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash. Adventist Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamstress

12b. KIND OF BUSINESS OR INDUSTRY: Garment

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Takoma Park

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS / ZIP CODE: ~~6606 Westmoreland Avenue 20912~~ 7051 Carroll Ave. # 512, Takoma Pk, Md. 20912

14. FATHER'S NAME FIRST: ~~William~~ Vilmos MIDDLE: LAST: Herczeg

15. MOTHER'S MAIDEN NAME FIRST: ~~Wilmosh~~ Malvina MIDDLE: LAST: ~~unknown~~ Krausz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 093 42 6627

17. INFORMANT: Elizabeth Ban: 6606 Westmoreland Avenue, ADDRESS: Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/20 19 87, to 2/20 19 87, that (I) (we) last saw the deceased alive on 2/20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Tipy - Wood

DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TIPAPOOR WOODWARD

22e. ADDRESS: 5530 WISCONSIN AV. CHEVY CHASE MD 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb 22, 1987

23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cem

23d. LOCATION CITY OR TOWN: Adelphi, COUNTY: STATE: Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Ives-Pearson F.H/ Falls Church, Virginia

25a. DATE REC'D BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Brickhouse

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

046360 MAR-9 '87

J. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 91
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUBY MIDDLE: DELLA LAST: BARBER

2a. DATE OF DEATH MONTH DAY YEAR: 2/28/87

2b. HOUR: 4:41 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: 10/27/19

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Kensington

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11101 West Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Kensington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 11101 West Avenue 20895

14. FATHER'S NAME FIRST: Joe MIDDLE: nmn LAST: Talbert

15. MOTHER'S MAIDEN NAME FIRST: Dora MIDDLE: Ann LAST: Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ——

16b. SOCIAL SECURITY NO.: 579-05-2295

17. INFORMANT (NAME, ADDRESS): Orville Chester Barber Jr. (son) 922 Maple Ave Rockville, Md. 20851

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic Coma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma Pancreas — 6 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1987, to 2/28, 1987, that (I) (we) last saw the deceased alive on 2/14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edgar H. Ledin DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 3/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDGAR H. LEDIN

22e. ADDRESS: 9801 Georgia Ave 20902 Silver Springs MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3/3/87

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN: Brentwood STATE: Maryland

24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike, Rockville, Maryland 20852

25a. DATE REC'D BY REGISTRAR: MAR 06 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

045063 FEB 25 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 92
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Gerald MIDDLE Albert LAST BARBOUR

2a. DATE OF DEATH (MONTH DAY YEAR): February 19, 1987

2b. HOUR: 11:55 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH (MONTH DAY YEAR): Jan. 17, 1912

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: American

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Germantown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 19515 Frederick Road Lot 161

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Restaurant -

12b. KIND OF BUSINESS OR INDUSTRY: Owner

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Germantown

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 19515 Frederick Road 20874

14. FATHER'S NAME: FIRST Albert MIDDLE LAST Barbour

15. MOTHER'S MAIDEN NAME: FIRST Josephine MIDDLE LAST (unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-03-1353

17. INFORMANT: Phyllis J. Barbour ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Nasopharyngeal Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from February 3, 19 87, to February 19, 19 87, that (I) ~~(we)~~ last saw the deceased alive on February 3, 19 87, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: Jules R. Lodish, DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/19/1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jules R. Lodish, M.D.

22e. ADDRESS: 2901 Olney Sandy Spring Rd., Olney, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/20/87

23c. NAME OF CEMETERY OR CREMATORY: Westview Mem. Pk.

23d. LOCATION: CITY OR TOWN Baltimore, COUNTY Maryland, STATE

24. FUNERAL DIRECTOR: NAME Olin L. Molesworth, P.A., ADDRESS Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 20 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 05293

044141 FEB

1. DECEASED NAME (PRINT) — FIRST: VIVIENNE — MIDDLE: H. — LAST: BARRETT

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☑ — MONTH 02 DAY 06 YEAR 1987

2b. HOUR A.M.

3. SEX: Fe

4. RACE: C

5. DATE OF BIRTH — MONTH 7 DAY 31 YEAR 22

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.

IF UNDER 1 YR. — MONTHS / DAYS

IF UNDER 24 HRS. — HOURS / MIN

2c. DATE PRONOUNCED DEAD — MONTH 02 DAY 07 YEAR 1987

2d. HOUR 1825 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6515 BROAD ST

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALES

12b. KIND OF BUSINESS OR INDUSTRY: INSURANCE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: BETHESDA

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 6515 BROAD ST. 20816

14. FATHER'S NAME — FIRST: JOSEPH — MIDDLE: W. — LAST: Hollidge

15. MOTHER'S MAIDEN NAME — FIRST: JOSEPHINE — MIDDLE: E. — LAST: JORDAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 579-12-8093

17. INFORMANT: SON JOHN B. BARRETT — ADDRESS: 20 WELLESLEY CR. GLEN ECHO, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — IN DEF

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH 02 DAY 06 YEAR 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): FOUND AT KITCHEN TABLE

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME

21f. LOCATION — STREET: 6515 BROAD ST. — CITY OR TOWN: BETHESDA — COUNTY: MONT — STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): DEPT MEDICAL EXAMINER DATE SIGNED 2-8-87

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MAYLE ADDRESS: 8200 WISCONSIN AV. BETHESDA MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-11-87

23c. NAME OF CEMETERY OR CREMATORY: ORLEAN CEM.

23d. LOCATION — CITY OR TOWN: ORLEAN — COUNTY: — STATE: VIRGINIA

24. FUNERAL DIRECTOR — NAME: DEVOL FUNERAL HOME — ADDRESS: WASH. D.C.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

FEB 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

044587 FEB 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 94
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST May MIDDLE Stott LAST Bauer

2a. DATE OF DEATH: MONTH February DAY 9 YEAR 1987

2b. HOUR: 4:30AM

3. SEX: female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH April DAY 19 YEAR 1894

6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Kensington

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kensington Gardens Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Adm. Assistant

12b. KIND OF BUSINESS OR INDUSTRY: N.C.W.C.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 8811 Colesville Rd. #703 20910

14. FATHER'S NAME: FIRST Samuel MIDDLE Thompson LAST Stott

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE McClelland LAST Knowles

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-46-7243

17. INFORMANT: Mary E. Alder ADDRESS: daughter same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiovascular collapse –

DUE TO, OR AS A CONSEQUENCE OF (b) cardiac arrhythmias – ASHD –

DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): anemia – chronic macrocytic normoblastic

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/11, 1986, to 2/5, 1987, that (I) (we) last saw the deceased alive on 2/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph M. Solinas DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph Solinas, M.D.

22e. ADDRESS: 9801 Georgia Ave., Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 12, 1987

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (CITY OR TOWN, COUNTY): Suitland Prince Georges Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

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J45883 MA
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that a death certificate be executed within 24 hrs. after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file the entire papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05295
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ERNEST R. BAUR, JR.

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 23 1987

2b. HOUR: 7:17 P M

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: MAY 7 1911

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DISTRICT OF COLUMBIA UNITED STATES

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Civil Engineer

12b. KIND OF BUSINESS OR INDUSTRY: U.S.A.F.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: BETHESDA

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 4402 WEST VIRGINIA AVE 20814

14. FATHER'S NAME FIRST MIDDLE LAST: Ernest R. Baur, Sr.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: MARGARET M. BUGGY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): 1947-1968

16b. SOCIAL SECURITY NO.: 579-09-6013

17. INFORMANT: Dorothy M. Baur wife — ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 14 19 87 to FEBRUARY 23 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward P. Fox — DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]

22c. DATE SIGNED: 25 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDWARD P. FOX, LT, MC, USNR

22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 27, 1987

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Arlington Virginia

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Gordon-Pendere

1

045435 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Page 4 may be retained by the medical examiner.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 90
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST ZOA MIDDLE P. LAST BEALL

2a. DATE OF DEATH: MONTH 2 DAY 21 YEAR 87

2b. HOUR: 8 05 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH May DAY 28 YEAR 1906

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: S.S.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Althea Nursing Home Woodland

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): US Gov't.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: S.S.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 102 University Blvd. E. 20901

14. FATHER'S NAME: FIRST George MIDDLE H. LAST Pflanz

15. MOTHER'S MAIDEN NAME: FIRST Zoa MIDDLE LAST Pinckney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 107 01 4928A

17. INFORMANT: Stewart Pflanz (Brother) ADDRESS: 7 Lamp Lighter Lane Newington, Conn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca Breast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 65, to 2-21 19 87, that (I) [redacted] last saw the deceased alive on 2-17 19 87 and that in (my) [redacted] opinion death occurred on the date and hour and from the causes stated above. (I) [redacted] did [redacted] view the body after death.

22b. SIGNATURE: D Sengstack MD. DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-21-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. George Sengstack

22e. ADDRESS: 9241 Columbia Blvd. S.S.Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/ 25 /87

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek

23d. LOCATION: CITY OR TOWN Washington, D.C. COUNTY STATE

24. FUNERAL DIRECTOR: Hines/Rinaldi 11800 New Hamp. Ave. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

045954 MAR 4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 052 91

REG. NO.

1. DECEASED'S NAME (TYPE OR PRINT) FIRST: ANNA MIDDLE: E. LAST: BELL

2a. DATE OF DEATH MONTH: 2 DAY: 27 YEAR: 87

2b. HOUR: M.

3. SEX: FEMALE

4. RACE: BLACK

5. DATE OF BIRTH MONTH: 11/1 DAY: 1/07 YEAR:

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: S.S

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): H.C.H.

12a. USUAL OCCUPATION (TYPE OF WORK DURING MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Mont.

13c. CITY OR TOWN: S.S.

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS / ZIP CODE: 1512 Crestline S.S. Md. 20904

14. FATHER'S NAME FIRST: Robert MIDDLE: E. LAST: Gould

15. MOTHER'S MAIDEN NAME FIRST: CLARA MIDDLE: LAST: TILGHMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 209-12-4417

17. INFORMANT: Daughter ADDRESS: 1512 Crestline S.S. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Terminal Stroke — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 wk.

DUE TO, OR AS A CONSEQUENCE OF (b): Inanition — 4-6 mo

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of the pancreas — 6 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 2/19/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Partial Gastric obstruction

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18, 19 87, to 2/27, 19 87, that (I) (we) last saw the deceased alive on 2/27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. Eichler

22e. ADDRESS: 3915 Fenton St. Wheat. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3-5-87

23c. NAME OF CEMETERY OR CREMATORY: Rolling Green

23d. LOCATION CITY OR TOWN: West Chester, Pa. COUNTY / STATE

24. FUNERAL DIRECTOR NAME: John T. Rhines Co. ADDRESS: 3015 12th St., N.E., D.C. 20017

25a. DATE REC'D. BY REGISTRAR: MAR 03 1987 REGISTRAR'S SIGNATURE: Julia Dickson Parker

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit Permit. This permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05298

45279 FEB 2

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles MIDDLE: D. LAST: Bennett

2a. DATE OF DEATH MONTH DAY YEAR: 02 15 87

2b. HOUR: 12:45 P.M.

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: 04 20 03

6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YR. MONTHS 10 DAYS 11 IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.Y. - USA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired / PUBLICIST.

12b. KIND OF BUSINESS OR INDUSTRY: PUBLIC RELATIONS

99999

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: VA.

13b. COUNTY: NONE

13c. CITY OR TOWN: ALEXANDRIA

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 5770 DUNSTER CT. 22311

14. FATHER'S NAME FIRST MIDDLE LAST: CHARLES F. BENNETT

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: ELIZABETH UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-28-3224

17. INFORMANT: Rose Sampson ADDRESS: 5770 Dunster Ct. #171 Alex, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic Shock

DUE TO, OR AS A CONSEQUENCE OF (c) ruptured abdominal aneurysm

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

atherosclerotic cardiovascular disease, Heart failure

19a. DATE OF OPERATION: 2/15/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: ruptured aneurysm

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 87 to 2/15 19 87, that (I) (we) last saw the deceased alive on 2/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Barry Levin MD DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY F. LEVIN, MD

22e. ADDRESS: 4801 MASS AVE, N.W. - WASH, D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 2-17-1987

23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREM.

23d. LOCATION CITY OR TOWN COUNTY STATE: RIVERDALE, P.G. Md.

24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO. ADDRESS: 20910 INC, SILVER SPRING Md.

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Dandridge

99999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place a notice of death in two newspapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 indicates injury, or other traumatic event, the medical examiner must be notified immediately. In such event, the hospital or funeral director may not release the body without the medical examiner's permission.

RELEASED BY MEDICAL EXAMINER

044169 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05299

1. DECEASED NAME (TYPE OR PRINT) FIRST: DELPHINE MIDDLE: L. LAST: BESSIERES

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 8, 1987

2b. HOUR: 9:50 AM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 22, 1894

6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: KENSINGTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): KENSINGTON GARDENS NURSING CNT.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: KENSINGTON

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 11302 CONNECTICUT AVE. / 20895

14. FATHER'S NAME FIRST: EDMOND MIDDLE: - LAST: VILLERMAUX

15. MOTHER'S MAIDEN NAME FIRST: MARY MIDDLE: - LAST: COLNEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): NONE

16b. SOCIAL SECURITY NO.: 163-34-7907

17. INFORMANT: MARY WALLAS (DAUGHTER) ADDRESS: 11310 HALETHORPE TERR. GERMANTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 YRS

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I / ~~this hospital~~) attended the deceased from JAN. 19 70 to FEB. 8 19 87 that (I / ~~I~~) last saw the deceased alive on JANUARY 16 19 87 and that in (my / ~~our~~) opinion death occurred at the date and hour and from the causes stated above. (I / ~~we~~) (did / did not) view the body after death.

22b. SIGNATURE: Richard H. Pollen

DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: FEB/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RICHARD POLLEN, M.D.

22e. ADDRESS: 10400 CONNECTICUT AVE. #606 KENSINGTON, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: FEB/9/87

23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY

23d. LOCATION CITY OR TOWN: RIVERDALE COUNTY: PG CO. STATE: MARYLAND

24. FUNERAL DIRECTOR NAME: W.W. CHAMBERS CO., INC. ADDRESS: 8655 GEORGIA AVE. SILVER SPRING, MD.

25a. DATE REC'D BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045031 FEB 25

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05300
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: George David Beveridge, Jr.		2a. DATE OF DEATH MONTH DAY YEAR: February 14, 1987	2b. HOUR: 7;35 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 5, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9302 Kingsley Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): V. Pres.	12b. KIND OF BUSINESS OR INDUSTRY: Riggs Bank

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Montgomery	Bethesda	YES [X] NO [ ]	9302 Kingsley Ave. 20814

14. FATHER'S NAME FIRST / MIDDLE / LAST: George David Beveridge, Sr.			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Lillian A. Little	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes.	(IF YES, GIVE WAR OR DATES): WW II-Korea	16b. SOCIAL SECURITY NO.: 579-16-7922	17. INFORMANT: Betty J. Beveridge	ADDRESS: Same as item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Leukemia — 16 Months

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct, 19 85, to Feb. 14, 19 87, that (I) (we) last saw the deceased alive on Feb. 13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Oscar Mann M.D.	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: Feb.15,1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Oscar Mann M.D.	22e. ADDRESS: 3301 New Mexico Ave NW Washington, D.C. 20016	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/18/87	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, MD
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDR.: 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR: FEB 20 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudacs

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The [illegible] that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The remaining pages above carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 indicates any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

x

042657 FEB 1-87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05301
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jean MIDDLE: L. LAST: Billhimer		2a. DATE OF DEATH MONTH DAY YEAR: Feb. 1, 1987	2b. HOUR: 11:27 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 3 1919	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Govt. Montg. County
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 9039 Sligo Creek Pkwy. 20901
14. FATHER'S NAME FIRST: Joseph MIDDLE: LAST: Walling		15. MOTHER'S MAIDEN NAME FIRST: Enda MIDDLE: LAST: Levier	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 578-01-7529	17. INFORMANT: Edwin S. Billhimer, Jr. - husband-(same as 13e ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST — —

DUE TO, OR AS A CONSEQUENCE OF (b) PRESUMED PULMONARY EMBOLUS — —

DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA, INTRA-ABDOMINAL — 2 MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 11-26-87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: ADENOCARCINOMA, INTRA-ABDOMINAL	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [X]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3/15 19 78, to 2/1 19 87, that (I) (we) last saw the deceased alive on 1/31 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/2/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arnold Levy, MD. — 22e. ADDRESS: 1106 Spring Street, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-5-1987	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood COUNTY: Pr. Georges STATE: Md.
24. FUNERAL DIRECTOR: Hines-Rinaldi Funeral Home	ADDRESS: 11800 N.H. Ave., Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 2 1987	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Medical examiner must be notified of cases.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified of cases.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

044450 FEB 19

17 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05302
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST ALICE MIDDLE Ashford LAST BISSELLE

2a. DATE OF DEATH (MONTH DAY YEAR): 2/7/87

2b. HOUR: Mid 12 night

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH (MONTH DAY YEAR): Oct. 23, 1901

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NY

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CARRIAGE HILL - BETHESDA

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Mont.

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 5215 Cedar Lane 20814

14. FATHER'S NAME FIRST Charles MIDDLE W. LAST Ashford

15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE LAST Jost

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-60-3969

17. INFORMANT: Charles A. Bisselle ADDRESS 7706 Georgetown Pike McLean, VA 22102

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

DUE TO, OR AS A CONSEQUENCE OF (b) LEFT CEREBRO VASCULAR ACCIDENT. — 3 WEEKS.

DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS — YEARS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3.24 19 86 to 2.7. 19 87, that (I) (we) last saw the deceased alive on 2.6 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Saulius Naujokaitis, MD DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-7-87.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SAULIUS NAUJOKAITIS M.D

22e. ADDRESS: 3301 NEW MEXICO AVE. N.W. WASHINGTON, D.C. 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/10/87

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.

23d. LOCATION CITY OR TOWN: Suitland, MD COUNTY STATE

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

15 043862 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 03
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Gloria MIDDLE: Jean LAST: Black		2a. DATE OF DEATH MONTH DAY YEAR: Feb. 6, 1987	2b. HOUR: 6:55 a. M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: November 8, 1940	6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 25 Bannister Court	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife	12b. KIND OF BUSINESS OR INDUSTRY: home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 25 Bannister Court 20879

14. FATHER'S NAME FIRST: Charles MIDDLE: LAST: Dettmer	15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: LAST: Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ———	16b. SOCIAL SECURITY NO.: 220 40 3696	17. INFORMANT: James M. Black (husband) ADDRESS: same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Amyotrophic lateral sclerosis — 8 months

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~the~~ (this ~~hospital~~ HIS) attended the deceased from July, 19 86, to Feb. 6, 19 87, that ~~I~~ (we) last saw the deceased alive on Oct. 27, 19 86, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) ~~did~~ (did not) view the body after death.

22b. SIGNATURE: William H. Silverman	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 2-7-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM H. SILVERMAN	22e. ADDRESS: 6111 EXECUTIVE BLVD. ROCKVILLE, MD 20852	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/10/87	23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Falls Church, Virginia
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR: FEB 11 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05304

044598 FEB 19 87

1. DECEASED NAME (TYPE OR PRINT) FIRST: Oswald MIDDLE: LAST: Bodden		2a. DATE OF DEATH MONTH DAY YEAR: 2 13 87	2b. HOUR: 2.43 P.M.
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: December 15 1923	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Indies	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrician	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Adelphi	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 7302 Riggs Road 20783
14. FATHER'S NAME FIRST MIDDLE LAST: Eric Bodden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Elenora Bodden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-70-7203	17. INFORMANT ADDRESS: Kenrick Bodden/1220 Emerson St N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recent Pulmonary Embolic

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. S. Locke, III, MD	22e. ADDRESS: 8580 Second Ave Silver Spring, Md. 20910	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/21/87	23c. NAME OF CEMETERY OR CREMATORY: Gates of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE: Ma Wheaton Maryland
24. FUNERAL DIRECTOR NAME: McGuire Funeral Service ADDRESS: 7400 Georgia Ave. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR: FEB 18 1987	25b. REGISTRAR'S SIGNATURE: Julia Dandridge-Lindsay

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

044589 FEB 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 05305

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Elizabeth MIDDLE: C. LAST: Bogner

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☑ — MONTH 2 DAY 11 YEAR 19 87

2b. HOUR 8:00 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH 5 DAY 20 YEAR 1900

6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. — IF UNDER 1 YR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH 2 DAY 12 YEAR 19 87

2d. HOUR 7:45 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10201 Grosvenor Place # 820

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auditor

12b. KIND OF BUSINESS OR INDUSTRY: Internal Revenue

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS: 10201 Grosvenor Place /20852

14. FATHER'S NAME — FIRST: Henry MIDDLE: LAST: Frahme

15. MOTHER'S MAIDEN NAME — FIRST: Mary MIDDLE: M. LAST: Fischer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 120-12-3509

17. INFORMANT: Elizabeth B. Lawton — ADDRESS: 76 Wampanoag Trail RFD Dennis, MA 02638

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John Tauber M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2-12-87

EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 Wisconsin Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb. 15, 1987

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION — CITY OR TOWN: Alexandria COUNTY STATE: Virginia

24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home, Bethesda/Chevy Chase, Inc. ADDRESS 7557 Wisconsin Ave Bethesda, Maryland 20814

25a. DATE REC'D BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

044381 FEB 17 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05309
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): Audrey W. Bond
2a. DATE OF DEATH: February 12, 1987
2b. HOUR: 5:35PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 11 24 02
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Sandy Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 17340 Quaker Lane 20860

14. FATHER'S NAME: Charles H Wallich
15. MOTHER'S MAIDEN NAME: Ella May Harding
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 217 36 8623
17. INFORMANT: Audrey Schneider (Daughter) ADDRESS: 4809 Wyaconda Rd. Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiopulmonary expiration — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2/12/87
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive heart failure — 2/11/87
DUE TO, OR AS A CONSEQUENCE OF (c): Renal failure, osteomyelitis — 1/10/87
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pneumonia, GI bleeding, Thyroid disease
19a. DATE OF OPERATION: '76
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pneumonia
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 87, to 2/12, 19 87, that (I) (we) last saw the deceased alive on 2/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Arthur Suryadi MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ARTHUR SURYADI MD
22e. ADDRESS: 18111 Prince Philip Dr. Olney MD 20832

23a. BURIAL, CREMATION, REMOVAL: Burial
23b. DATE: 2/16/87
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION (CITY OR TOWN): Burtonsville COUNTY: Mont. STATE: Md.
24. FUNERAL DIRECTOR: Hines/Rinaldi ADDRESS: 11800 New Hamp. Ave. S.S. Md.
25a. DATE REC'D. BY REGISTRAR: FEB 13 1987
25b. REGISTRAR'S SIGNATURE: Lois Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

124 30301
45646 MAR -2 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05307
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BONNIELL MIDDLE: JEAN LAST: B

2a. DATE OF DEATH MONTH DAY YEAR: 2-19-87

2b. HOUR: 11:30 P M

3. SEX: F

4. RACE: Canc

5. DATE OF BIRTH MONTH DAY YEAR: 1 30 27

6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Church

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Pr. Geo.

13c. CITY OR TOWN: College Park

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 9302 St. Andrews Place 20740

14. FATHER'S NAME FIRST: Clifford MIDDLE: P. LAST: Bruner

15. MOTHER'S MAIDEN NAME FIRST: Mabel MIDDLE: LAST: Whittaker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 340-22-0419

17. INFORMANT: Mr. David Bonnell

ADDRESS: 13508 Wisteria Dr. Germantown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Pulmonary Edema, Pulmonary Fibrosis, Aspiration Pneumonia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18, 1987, to 2/19, 1987, that (I) (we) last saw the deceased alive on 2/19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Antonio G. Uy MD

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANTONIO G. UY M.D.

22e. ADDRESS: 8311 Lund Blvd E #25 S.S. Md 20903

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 2-22-87

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board

ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: FEB 27 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requests that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

045604 FEB 27 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05308
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Lula MIDDLE: Geneva LAST: BOONE

2a. DATE OF DEATH (MONTH DAY YEAR): 2-23-87

2b. HOUR: 810 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH (MONTH DAY YEAR): Aug. 18, 1923

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: American

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady GROVE ADVENTIST HOSP.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Boyds

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 20201 Bucklodge Road 20841

14. FATHER'S NAME — FIRST: James MIDDLE: LAST: Tibbs

15. MOTHER'S MAIDEN NAME — FIRST: Flora MIDDLE: Edna LAST: (unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 217-16-2170

17. INFORMANT: Herbert A. Boone, Sr. ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC Small cell Lung Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 months

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I/this hospital) attended the deceased from June 1986 to Feb 23 1987 that (I/we) last saw the deceased alive on 2/23 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RAYA V. BOCCIA, MD

22e. ADDRESS: 14800 Physicians Ln #232 Rockville Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/27/87

23c. NAME OF CEMETERY OR CREMATORY: Resthaven Mem. Gd.

23d. LOCATION CITY OR TOWN: Frederick COUNTY: Md. STATE:

24. FUNERAL DIRECTOR NAME: Olin L. Molesworth, P.A. ADDRESS: Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 4 should be used to remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82 (VRA 15, 4)

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 053 09

0437 FEB 11 87

1. DECEASED NAME (TYPE OR PRINT) FIRST: EMA MIDDLE: E. LAST: Bordiga			2a. DATE OF DEATH MONTH 2 DAY 2 YEAR 87	2b. HOUR 3 15/A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH SEPT. DAY 9 YEAR 09	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ARGENTINA	7b. CITIZEN OF WHAT COUNTRY? ARGENTINA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	MONTGOMERY	WHEATON	YES ☒ NO ☐	2256 GEORGIAN WOODS PL. / 20902

14. FATHER'S NAME FIRST: MARCO MIDDLE: — LAST: ZORNITTA		15. MOTHER'S MAIDEN NAME FIRST: FRANCISCA MIDDLE: — LAST: ALBAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): NONE	16b. SOCIAL SECURITY NO.: 219-11-7825	17. INFORMANT: JULIA GRINSTEIN (DAUGHTER) ADDRESS: SAME AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC CANCER — 2 MONTHS

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 8 JAN, 19 87, to 2 FEB, 19 87, that I (we) last saw the deceased alive on 1 FEB, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~she~~) (did not) view the body after death.

22b. SIGNATURE: Walter E. Gooch MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2 Feb 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOCH MD	22e. ADDRESS: 2309 SHUREFIELD RD WHEATON MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: FEB. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY	23d. LOCATION CITY OR TOWN: RIVERDALE COUNTY: PG CO. STATE: MARYLAND
24. FUNERAL DIRECTOR NAME: W.W. CHAMBERS CO. INC. ADDRESS: 8655 GEORGIA AVE. SILVER SPRING, MD	25a. DATE REC'D. BY REGISTRAR: FEB 9 1987	25b. REGISTRAR'S SIGNATURE: Julia Gordon	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

044398 FEB

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05310

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHRISTOS MIDDLE: I. LAST: BOUBALOS

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH DAY YEAR: 2-10-87 19

2b. HOUR: M

3. SEX: Male

4. RACE: Greek

5. DATE OF BIRTH — MONTH DAY YEAR: 12 14 54

6. AGE (IN YEARS LAST BIRTHDAY): 33 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: 2-10-87 19

2d. HOUR: 6:25am

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Athens, Greece

7b. CITIZEN OF WHAT COUNTRY? Greece

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MOntgomery County MD

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): B&O Railroad at Randolph Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cook

12b. KIND OF BUSINESS OR INDUSTRY: Resturan

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 12205 Braxfield Ct. 20852

14. FATHER'S NAME FIRST MIDDLE LAST: Elias Boubalos

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Panorea Thrisanthea

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218 11 3449

17. INFORMANT ADDRESS: Mia Boubalos

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 6:12P 2-10-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): pedestrian struck by a train

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): railroad tracks

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: B&O railroad@ RandolphRd. Rockville,Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X].

ACTUAL SIGNATURE: Margarita A. Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-10-87

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell,M.D. ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-17 87

23c. NAME OF CEMETERY OR CREMATORY: National

23d. LOCATION CITY OR TOWN COUNTY STATE: Athens, Greece

24. FUNERAL DIRECTOR NAME ADDRESS: Capitol Mortuaty 1425 Maryland Ave. Wash.D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: Julia Gordon-Cochran

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH 17 (VR A15 ME (5))

044714 FEB 20 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 11
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Margery MIDDLE G. LAST Bourdeaux

2a. DATE OF DEATH: MONTH DAY YEAR February 12, 87

2b. HOUR: 10:00 AM

3. SEX: Female

4. RACE: Cauc.

5. DATE OF BIRTH: MONTH DAY YEAR 11/30/06

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary

12b. KIND OF BUSINESS OR INDUSTRY: School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Laytonsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 8510 Brink Rd. 20879

14. FATHER'S NAME: FIRST Bridges MIDDLE — LAST Girling

15. MOTHER'S MAIDEN NAME: FIRST Claribel MIDDLE — LAST Klayer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-36-8388

17. INFORMANT: Robert Bourdeaux ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4, 19 87, to 2/12, 19 87, that (I) (we) last saw the deceased alive on 2/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John G Lodmell DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/12/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN G LODMELL MD

22e. ADDRESS: 2801 Olney Sandy Spring Rd Olney MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: Feb. 16, 1987

23c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery

23d. LOCATION: CITY OR TOWN Gaithersburg, COUNTY Mont. STATE Md.

24. FUNERAL DIRECTOR: NAME MURIEL H. BARBER ADDRESS LAYTONSVILLE, MD. 20879

25a. DATE REC'D. BY REGISTRAR: FEB 19 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete and return papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified promptly.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045757 MAR -3 '87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05312
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSEPH MIDDLE C LAST Bowers
2a. DATE OF DEATH: MONTH 2 DAY 18 YEAR 87
2b. HOUR: 945 A.M.
3. SEX: male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH July DAY 2 YEAR 1902
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist
12b. KIND OF BUSINESS OR INDUSTRY: Navy Yard

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 1611 Oakview Drive 20903

14. FATHER'S NAME: FIRST Joseph MIDDLE LAST Bowers
15. MOTHER'S MAIDEN NAME: FIRST Anna MIDDLE LAST Cook
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 710-09-5637
17. INFORMANT: daughter June Hawkins ADDRESS: 10700 Stoneyhill Dr. Silver Spring, Md. 2090

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Lung Disease

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/17 19 87, to 2/18 19 87, that (I) (we) last saw the deceased alive on 2/18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B. Zinsmeister MD DEGREE: MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): B. ZINSMEISTER
22e. ADDRESS: 8830 Cameron St., Silver Spring, Md. 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 21, 1987
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION: CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.
25a. DATE REC'D. BY REGISTRAR: MAR 02 1987
25b. REGISTRAR'S SIGNATURE: Julia Dawson-Lenhart

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The remaining pages are carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045035 FEB 25 87

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 13
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Morris MIDDLE LAST Bloom
MORRIS BLOOM

2a. DATE OF DEATH: MONTH Feb DAY 16 YEAR '87
2b. HOUR: 9:20 P.M.

3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH July DAY 3 YEAR 1909
6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL OR FACILITY, GIVE STREET ADDRESS): SUBURBAN Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk
12b. KIND OF BUSINESS OR INDUSTRY: Drug store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS / ZIP CODE: 5721 Grosvenor Lane / 20814

14. FATHER'S NAME: FIRST (Unavailable) MIDDLE LAST Bloom
15. MOTHER'S MAIDEN NAME: FIRST Ida MIDDLE LAST Brill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 577-03-1565
17. INFORMANT: Lillian Greenspan, ADDRESS: 5410 Connecticut Ave., NW Washington, DC 20015

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT infection
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Reaction to surgery

19a. DATE OF OPERATION: 2/2/87
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abscess - Pelvic
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~(the hospital)~~ attended the deceased from Apr 1985 to date, that (I) ~~(we)~~ last saw the deceased alive on 2/16/87, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: Thos G. Ward M.D.
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/17/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thos G. WARD
22e. ADDRESS: 6116 Rahinwood, Bethesda 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 2-18-87
23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory
23d. LOCATION: CITY OR TOWN Alexandria, COUNTY STATE Virginia

24. FUNERAL DIRECTOR: NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009
25a. DATE REC'D. BY REGISTRAR: FEB 20 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudacs

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045198 FEB 26

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

87 05 3 1 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: EDWARD WARNER BRICE

2a. DATE OF DEATH MONTH DAY YEAR: FEB 19 1987

2b. HOUR: 10:30 AM

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH MONTH DAY YEAR: September 23 1916

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Wheaton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Educator

12b. KIND OF BUSINESS OR INDUSTRY: US Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE:

13b. COUNTY:

13c. CITY OR TOWN: Washington DC

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 7810 14th Street, N.W. 20012

14. FATHER'S NAME FIRST MIDDLE LAST: Jett Brice

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Carrie Heath

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 250-42-8404

17. INFORMANT: Creola Brice — ADDRESS: 7810 14th St. N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED
DUE TO, OR AS A CONSEQUENCE OF (b) STROKE
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC VASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION STREET CITY OR TOWN COUNTY STATE:

22a. I certify that (I) (~~this hospital~~) attended the deceased from 19 84 to 19 FEB 19 87 that (I) (~~we~~) last saw the deceased alive on 19 FEB 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 19 FEB 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOZH MD

22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/24/87

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek

23d. LOCATION CITY OR TOWN COUNTY STATE: Washington, D.C.

24. FUNERAL DIRECTOR NAME: McGuire Funeral Service — ADDRESS: 7400 Georgia Ave. Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining pages, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 999999

DHMH - 16 60M 7/84 (VRA 15, 4)

046128 MAR 5 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 15
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MARIAN — MIDDLE: BOWKER — LAST: BROMELL

2a. DATE OF DEATH — MONTH DAY YEAR: FEBRUARY 27, 1987

2b. HOUR: 9:35 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: January 27, 1903

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CARRIAGE HILL NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own home

13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 8316 Woodhaven Blvd. / 20817

14. FATHER'S NAME — FIRST: Jay — MIDDLE: Hinkley — LAST: Bowker

15. MOTHER'S MAIDEN NAME — FIRST: Cornelia — MIDDLE: — LAST: Edwards

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-50-8875

17. INFORMANT: John B. Bromell, — ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED.

DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE — 3 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 82, to February 27, 19 87, that (I) (we) last saw the deceased alive on January 7, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jon M. Wiseman — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jon M. Wiseman, M. D.

22e. ADDRESS: 5410 Connecticut Avenue, NW Washington, DC 20015

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-28-87

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION — CITY OR TOWN: Alexandria, — COUNTY — STATE: Virginia

24. FUNERAL DIRECTOR — NAME: RICHARD RAPP, INC. — ADDRESS: 1804 T ST., N.W., WASHINGTON, D.C. 20009

25a. DATE REC'D. BY REGISTRAR: MAR 04 1987

25b. REGISTRAR'S SIGNATURE: Lisa Baldwin-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. These pieces, removable ribbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045373 FEB 27

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05310
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Edna MIDDLE B. LAST Brown

2a. DATE OF DEATH: MONTH 2 DAY 22 YEAR 87

2b. HOUR: 0638 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Dec. DAY 22, YEAR 1916

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Beaver Creek, Md.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Shady Grove

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 15610 Field Rd. 20855

14. FATHER'S NAME: FIRST Hubert MIDDLE W. LAST Brining

15. MOTHER'S MAIDEN NAME: FIRST Emma MIDDLE M. LAST Armstrong

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 174-20-0593

17. INFORMANT: Mr. O. Roy Brown, ADDRESS: 15610 Fields Rd. Rockville, Md. 20855

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE BRONCHITIS — 7 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC OAT CELL CARCINOMA OF LEFT LUNG — 5 MOS

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from OCTOBER, 19 86, to FEBRUARY 21, 19 87, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 21, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~attended~~) (did not) view the body after death.

22b. SIGNATURE: James A. Brown MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/22/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES A. BROWN MD

22e. ADDRESS: 14800 PHYSICIANS LANE #232 ROCKVILLE, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-25-87

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION: CITY OR TOWN Hagerstown, COUNTY Wash. Co., STATE Md.

24. FUNERAL DIRECTOR: NAME Bast Funeral Home, ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713

25a. DATE REC'D BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, be sure to show any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045928 MAR

2011

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05317
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST HAROLD MIDDLE H. LAST BROWN

2a. DATE OF DEATH: MONTH 2 DAY 25 YEAR 87

2b. HOUR: 8:40 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 8 DAY 27 YEAR 95

6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Bedford, Mass.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Chevy Chase Retirement + Nursing

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY: Mailman

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Mont

13c. CITY OR TOWN: Potomac

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 7502 Heatherton Lane 20854

14. FATHER'S NAME: FIRST Daniel MIDDLE LAST Brown

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST MacRae

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW I

16b. SOCIAL SECURITY NO.: 026-34-2497

17. INFORMANT: Ruth B. Maxfield (daughter) — ADDRESS: same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Recurrent Strokes	Years
DUE TO, OR AS A CONSEQUENCE OF (c)	Cerebral Vascular Disease	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Congestive Heart Failure, Renal Insufficiency

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 2/23, 19 84, to 2/25, 19 87, that I (we) last saw the deceased alive on 2/23, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE: Robert H Blee MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert Henry Blee MD

22e. ADDRESS: 5454 Wisconsin Ave, Chevy Chase Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3/2/87

23c. NAME OF CEMETERY OR CREMATORY: Melrose Cemetery

23d. LOCATION: Brockton, Massachusetts

24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Knudsen

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045239 FEB 26 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 18
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Zenta MIDDLE N.M.N. LAST Bulle

2a. DATE OF DEATH: MONTH DAY YEAR February 17, 1987

2b. HOUR 10:29 a.m.

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH May DAY 2 YEAR 1898

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Latvia

7b. CITIZEN OF WHAT COUNTRY? Latvia

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12505 Montclair Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerical

12b. KIND OF BUSINESS OR INDUSTRY: Office Work

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 12505 Montclair Dr. 20904

14. FATHER'S NAME: FIRST UNKNOWN MIDDLE LAST

15. MOTHER'S MAIDEN NAME: FIRST UNKNOWN MIDDLE LAST Veber

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-48-2603

17. INFORMANT: son — ADDRESS: 10009 Branch View Court

Peter Freivalds — Silver Spring, Md. 20903

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Alzheimer's Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/11, 19 85, to 1/6, 19 87, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 18 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael E. Leibowitz, M.D.

22e. ADDRESS: 11120 N. Hampshire Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 20, 1987

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION: CITY OR TOWN Washington, D.C. COUNTY STATE

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE RECEIVED BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

6285 MAR -9 8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 17
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: ELMER C. BURKE		2a. DATE OF DEATH MONTH DAY YEAR: 2/27/87	2b. HOUR: 12:32 P.M.
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 5 13 11	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bank Officer.	12b. KIND OF BUSINESS OR INDUSTRY: Riggs Nat'l Bank

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES [ ] NO [ ]	10617 Tenbrook Dr. 20901

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Elmer Cleveland Burke	Daisy May Creel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W. II	577-22-2116	Viola H. Burke	wife same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction — immediate

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Chronic Obstructive Pulmonary disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/13 1983 to 2/27 1987 and (I) (we) last saw the deceased alive on 10/21 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE OF DECEDENT		22c. DATE SIGNED
Alan I. Kermaier, MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALAN I. KERMAIER MD	10513 Georgia Ave. S.S. MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	March 3, 1987	Parklawn Cemetery	Rockville Montgomery Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.	MAR 06 1987	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 87 05320

0432 FEB

1. DECEASED NAME (TYPE OR PRINT) FIRST: FRANCES MIDDLE: V. LAST: Burke
2a. DATE OF DEATH MONTH DAY YEAR: 2-2-87
2b. HOUR: 9:30 P M
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH MONTH DAY YEAR: 4-24-12
6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Asst. Dir. of Nursing
12b. KIND OF BUSINESS OR INDUSTRY: Washington Hosp. Center

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 9918 Gardiner Ave 20902

14. FATHER'S NAME FIRST: Samuel MIDDLE: LAST: Veasey
15. MOTHER'S MAIDEN NAME FIRST: Lula MIDDLE: LAST: Roberts
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-24-3000
17. INFORMANT: nephew Gary Lawson
ADDRESS: 9983 Good Luck Road, T-2 Seabrook, Md. 20706

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 d
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myelomonocytic Leukemia — 1 mo
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Gastrointestinal bleeding, Diarrhea, Breast cancer

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May 2/2 19 81 to 2/2 19 87 that (I) (we) last saw the deceased alive on 2/2 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Peter Sherer MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter Sherer MD
22e. ADDRESS: 3947 Ferrara Dr. Wheaton md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 6, 1987
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Montgomery, Md.
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr.
ADDRESS: 500 University Blvd. West, Silver Spring, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 6 1987
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on page 1, report any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

44582 FEB 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR — REG. NO. 05321

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE E. LAST Burke
2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐: MONTH Feb DAY 10 YEAR 1987
2b. HOUR 12 AM/PM
3. SEX: F
4. RACE: W
5. DATE OF BIRTH: April 7 1896 (YEAR 90)
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 10 YEAR 1987
2d. HOUR 12 AM/PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD
10. CITY OR TOWN OF DEATH: Sil. Spg
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Montg
13c. CITY OR TOWN: Sil Spg
13d. INSIDE CITY LIMITS? YES ☐ NO
13e. STREET ADDRESS: 1212 Corwin Dr.

14. FATHER'S NAME — FIRST Alfred MIDDLE E. LAST Phelps
15. MOTHER'S MAIDEN NAME — FIRST Susan MIDDLE LAST Goodwin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 214-28-2674
17. INFORMANT: son Francis V. Burke — ADDRESS: 1815 August Dr. Silver Spring, Md. 20902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb. 10, 1987
EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 13, 1987
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION — CITY OR TOWN: Arlington / COUNTY / STATE: Virginia

24. FUNERAL DIRECTOR — NAME: Francis J. Collins, Jr. — ADDRESS: 500 University Blvd. West, Silver Spring, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 18 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

045629 MAR - 2 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 87 05322

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALDEN MIDDLE: S. LAST: BUTLER				2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 2 DAY 20 YEAR 19 87	2b. HOUR M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH July DAY 22, YEAR 1936	6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH 2 DAY 20 YEAR 19 87 — 2d. HOUR 1:15 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARITAL STATUS: MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Md.	13b. COUNTY: Montg.	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 13 School Drive #102/ 20878	
14. FATHER'S NAME FIRST: James MIDDLE: Carroll LAST:				15. MOTHER'S MAIDEN NAME FIRST: Janie MIDDLE: Awkward LAST:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 218-34-6658		17. INFORMANT: Debra Butler (daughter)	ADDRESS: 17105 ~~Ring~~ James Way, #301 Gaithersburg, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Drowning

9104

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Arteriosclerotic cardiovascular disease and seizure disorder

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR ? A.M. P.M. MONTH 2-20- DAY YEAR 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject drowned in bathtub.
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home	21f. LOCATION STREET: 13 School Dr., CITY OR TOWN: Gaithersburg, COUNTY: Montgomery, STATE: MD

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 2-21-87

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-25-87	23c. NAME OF CEMETERY OR CREMATORY: Ash Memorial Cemetery	23d. LOCATION CITY OR TOWN: Sandy Spring, COUNTY: Montg. STATE: MD
24. FUNERAL DIRECTOR NAME: George R. Snowden	ADDRESS: 246 N. Washington St. Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR: FEB 26 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

45707 MAR -3 87

17- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05323

1. DECEASED NAME (TYPE OR PRINT): FRANK — FIRST: Frank — MIDDLE: J. — LAST: Callahan

2a. DATE OF DEATH: MONTH 2 DAY 28 YEAR 87

2b. HOUR: 5 A.M.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 3 DAY 4 YEAR 11

6. AGE (IN YEARS-LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 25 E. Wayne Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: GSA US Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 25 E. Wayne Ave. 20901

14. FATHER'S NAME — FIRST: Frank — MIDDLE: — LAST: Callahan

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: C. — LAST: Hope

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): WWII — (IF YES, GIVE WAR OR DATES): Navy

16b. SOCIAL SECURITY NO.: 216 44 3471

17. INFORMANT: Jane Callahan (Wife) — ADDRESS: Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — 2 weeks.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c) Renal Insufficiency — 2 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/29/79, 19__, to 2/18, 19 87, that (I) (we) last saw the deceased alive on 2/18/87, 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Max G. Sherer MD — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Max G. SHERER MD

22e. ADDRESS: 800 Pershing Dr. Silver Spring, Md 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 3/3/87 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven — 23d. LOCATION — CITY OR TOWN: S.S. — COUNTY: Mont. — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Hines/RinAldi — ADDRESS: 11800 New Hamp. Ave. S.S. Md.

25a. DATE REC'D BY REGISTRAR: MAR 02 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Parker Robertson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low registrar assures that the death certificate has been signed by the attending physician and should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OK by Dr. John J. Pogue Med. Exam.

BP____

DHMH - 16 60M 7/84 (VRA 15, 4)

045917 MAR

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 87 05324

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ralph — MIDDLE: — LAST: Cannon

2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ — MONTH Feb DAY 20 YEAR 1987

2b. HOUR 1:45 ☒ P.M. ☐ A.M.

3. SEX: M

4. RACE: Blk

5. DATE OF BIRTH — MONTH Oct. DAY 4 YEAR 1932

6. AGE (IN YEARS AT BIRTHDAY): 54 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD — MONTH Feb DAY 20 YEAR 1987

2d. HOUR 1:45 ☒ P.M. ☐ A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silv Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Guard

12b. KIND OF BUSINESS OR INDUSTRY: National Gallery of Art

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Mont.

13c. CITY OR TOWN: Sil. Spg

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 2544 Rees Rd Apt. 2091P

14. FATHER'S NAME — FIRST: Leroy — MIDDLE: — LAST: Cannon

15. MOTHER'S MAIDEN NAME — FIRST: Murdie — MIDDLE: — LAST: Woods

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 102-42-6337

17. INFORMANT: Leroy Cannon — Father — ADDRESS: 86 Carolina Avenue Hamstead, New York 11550

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sub Arachnoid Hemorrhage

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): MEDICAL EXAMINER — DATE SIGNED: Feb 20 1987

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Road Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 25, 1987

23c. NAME OF CEMETERY OR CREMATORY: Greenfield Cemetery

23d. LOCATION — CITY OR TOWN: Hamstead — COUNTY: Nassau — STATE: New York

24. FUNERAL DIRECTOR — NAME: Francis J. Collins, Jr. — ADDRESS: 500 University Blvd. W. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

045461 FEB 27 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 25
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: CAROL LYNN CAMP

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 17 1987

2b. HOUR: 10:12 P M

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 15 1987

6. AGE (IN YEARS LAST BIRTHDAY): YRS. IF UNDER 1 YEAR: MONTHS DAYS 2 IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: VIRGINIA

13b. COUNTY: PRINCE WM.

13c. CITY OR TOWN: QUANTICO

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: QTRS 2207E 22134

14. FATHER'S NAME FIRST MIDDLE LAST: MICHAEL GORDON CAMP

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: SANDRA GAY WARDRIP

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: N/A

17. INFORMANT ADDRESS: MICHAEL G.CAMP, QTRS 2207E, QUANTICO, VA

99999

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PREMATURITY

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 15, 19 87, to FEBRUARY 17, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD. DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 19 Feb '87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): B. M. GASTON, LT, MC, USNR

22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 20 Feb 87

23c. NAME OF CEMETERY OR CREMATORY: Onslow Memorial Park

23d. LOCATION CITY OR TOWN COUNTY STATE: Jacksonville, NC

24. FUNERAL DIRECTOR NAME ADDRESS: Capitol Funeral Service, Falls Church, VA

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 999999

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

75472 FEB 27 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 / REG. NO. 053 26

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: EDNA E. CAMPBELL

2a. DATE OF DEATH MONTH DAY YEAR: 2 18 87

2b. HOUR: 6 30A M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH MONTH DAY YEAR: 3 23 18

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Montg

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 14721 Blanton Rd. 20904

14. FATHER'S NAME FIRST MIDDLE LAST: Norman Smith

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Anna Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-34-5280

17. INFORMANT ADDRESS: James Adams (nephew) Same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) resp. failure — terminal

DUE TO, OR AS A CONSEQUENCE OF (b) advanced chronic lungdis — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): gastric Ca with hemorrhage, cachexia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-17 19 74 to 2-18 1987 that (I) (this hospital) last saw the deceased alive on 2-17 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (this hospital) (did not) view the body after death.

22b. SIGNATURE: Geo Sengstack DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-18-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): George R. Sengstack, M.D.

22e. ADDRESS: 9241 Columbia Blvd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-23-87

23c. NAME OF CEMETERY OR CREMATORY: Good Hope Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Silver Spring, Montg. MD

24. FUNERAL DIRECTOR NAME ADDRESS: George R. Snowden 246 N. Washington Rockville, MD 20850

25a. DATE REC'D BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045305 FEB 20 87

Item 13 e Phone CN

FOR STATE REGISTRAR 2-27-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05321

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lawrence MIDDLE: NMN LAST: Campbell		2a. DATE OF DEATH MONTH 2 DAY 15 YEAR 87	2b. HOUR 0530 M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: February 16, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montg. Co. MD.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Private
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D.C.	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 4705 8th ST N.E. 99992
14. FATHER'S NAME FIRST: William MIDDLE: Campbell LAST:		15. MOTHER'S MAIDEN NAME FIRST: Jessie MIDDLE: LAST: Jennings	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 223-03-2898	17. INFORMANT (WIFE) ADDRESS: THELMIA CAMPBELL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	1wk
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic Bladder Cancer	1 1/2 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [X]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 15 Nov, 19 85, to 15 Feb, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) last saw the deceased alive on 14 Feb, 19 87, and (did) (did not) view the body after death.

22b. SIGNATURE: Thomas A. Bensinger	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/15/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS A. BENSINGER		22e. ADDRESS: 7525 Greenway Cir Drive Greenbelt Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-19-87	23c. NAME OF CEMETERY OR CREMATORY: Lincoln	23d. LOCATION CITY OR TOWN: Suitland MD COUNTY: 20770
24. FUNERAL DIRECTOR NAME: Frazier's Funeral Home	ADDRESS: 389 Rhode Island Aveneu, N.W. Wash.D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 25 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] the papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] event, the medical [illegible] must be [illegible] at once.

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05328

044 6 FEB

1. DECEASED NAME (TYPE OR PRINT): FIRST LENA MIDDLE H. LAST CAROW

2a. DATE OF DEATH: MONTH 02 DAY 09 YEAR 87

2b. HOUR 6 PM

3. SEX: F

4. RACE: CAUC

5. DATE OF BIRTH: MONTH 12 DAY 08 YEAR 1901

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WOODSTOCK, VA

7b. CITIZEN OF WHAT COUNTRY?: US

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: ROCKVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): COLLINGSWOOD NRSG. CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 6530 Wiscasset Rd 20816

14. FATHER'S NAME: FIRST GEORGE MIDDLE LAST Stickley

15. MOTHER'S MAIDEN NAME: FIRST Alice MIDDLE LAST Gochenour

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES.

(IF YES, GIVE WAR OR DATES): WWI

16b. SOCIAL SECURITY NO.: 220-40-4937A

17. INFORMANT: Herbert Carow. ADDRESS: 6530 Wiscasset Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b) Senile Dementia — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~this hospital~~ attended the deceased from 11-17, 1986, to 1-9, 1987, that (I) (we) last saw the deceased alive on 1-29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Russell M. Tilley, Jr. M.D.

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-9-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Russell M. Tilley, Jr.

22e. ADDRESS: Collingwood Nursing Home

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2/13/87

23c. NAME OF CEMETERY OR CREMATORY: Massanutten Cemetery

23d. LOCATION: CITY OR TOWN Woodstock, COUNTY STATE Virginia

24. FUNERAL DIRECTOR: NAME IVES-Pearson F. Home ADDRESS Arl, VA.

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

8 043856

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 05329 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: PHY LIS MIDDLE: Beshore LAST: CARROLL

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ — MONTH 2 DAY 7 YEAR 1987

2b. HOUR A M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: Sept. 21, 1927

6. AGE (IN YEARS LAST BIRTHDAY): 59 RS. — IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD — MONTH 02 DAY 07 YEAR 1987

2d. HOUR 10:00 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9722 HOLMHURST RD

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: BETHESDA

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 9722 HOLMHURST RD 20817

14. FATHER'S NAME — FIRST: Parker MIDDLE: Jacob LAST: Beshore

15. MOTHER'S MAIDEN NAME — FIRST: Reba MIDDLE: Estella LAST: Jenkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-24-9111

17. INFORMANT: Linda Carroll (daughter) ADDRESS: same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY ARREST	ACUTE
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF	ACUTE PULMONARY INFECTION	1-2 WKS
DUE TO, OR AS A CONSEQUENCE OF (c)	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	INDEF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HYPERTENSION

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. A MONTH 2 DAY 7 YEAR 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): FOUND IN BED

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME

21f. LOCATION — STREET: 9722 HOLMHURST RD CITY OR TOWN: BETHESDA COUNTY: MONT STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Francis C Mayle M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED: 2/19/87

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MAYLE ADDRESS: 8200 WISCONSIN AVE BETHESDA MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/9/87

23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory

23d. LOCATION — CITY OR TOWN: Alexandria COUNTY: Virginia STATE: Va

24. FUNERAL DIRECTOR — NAME: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: FEB 11 1987

25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 [illegible] AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN [illegible] PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-184 25M BP

DHMH - 17 (VR A15 ME (5))

045859 MAR - 4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR: WALTER

REG. NO. 87 05330

1. DECEASED NAME (TYPE OR PRINT): FIRST WALTER MIDDLE CARTER LAST

2a. DATE OF DEATH: MONTH 2 DAY 19 YEAR 87

2b. HOUR: 10:50 AM

3. SEX: MALE

4. RACE: Black

5. DATE OF BIRTH: MONTH 05 DAY 25 YEAR 22

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S.C.

7b. CITIZEN OF WHAT COUNTRY?: YES

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BEL PRE HEALTH CARE CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Retired

13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN: WASHINGTON, D.C.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 1601 Isherwood St., NE Apt #3

14. FATHER'S NAME: FIRST WALTER MIDDLE T. LAST CARTER

15. MOTHER'S MAIDEN NAME: FIRST Zadie MIDDLE LAST Brockman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 249-28-2394

17. INFORMANT: Georgia Mae Carter (wife) ADDRESS: 1601 Isherwood St. NE Apt #3 WASH., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of The Oropharynx — 6 mos

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Seizure disorder -

19a. DATE OF OPERATION: 10/8/86

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinomas of Oropharynx

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/12, 1987, to 2/19, 1987, that (I) (we) last saw the deceased alive on 2/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. J. Benack MD

22e. ADDRESS: 4115 Colie Dr. Wheaton Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 27 Feb '87

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION: CITY OR TOWN Brentwood COUNTY PG MD

24. FUNERAL DIRECTOR: NAME Dudley & Son Funeral Home ADDRESS 3200 Rhode Island Ave Mt. Rainier, MD

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsey

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

045213 FEB 2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. 87 05331

1. DECEASED NAME (TYPE OR PRINT): FIRST BLANCHE MIDDLE E. LAST CASTLE
BLANCHE E. CASTLE

2a. DATE OF DEATH: MONTH 2 DAY 17 YEAR 1987
2b. HOUR 0520 M

3. SEX: F
4. RACE: B
5. DATE OF BIRTH: MONTH 10 DAY 25 YEAR 00
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HRS. MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Prince Georges
13c. CITY OR TOWN: LAUREL
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS / ZIP CODE: 14711 BOWIE RD. #302

14. FATHER'S NAME: FIRST William MIDDLE LAST Bell
15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST Cromwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): UNKNOWN
(IF YES, GIVE WAR OR DATES): None
16b. SOCIAL SECURITY NO.: 215-20-3694
17. INFORMANT: Barry McManus-Grandson
ADDRESS: 3199 Kenross Circle, Herndon, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Probable intestinal infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic intestinal bleeding

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-3, 19 87, to 2-14, 19 87, that (I) (~~was~~ last saw the deceased alive on 2-16, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) ~~was~~ (~~this~~ did not) view the body after death.
22b. SIGNATURE: Michael N Peskin
DEGREE: MD
ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/17/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael N Peskin
22e. ADDRESS: W.A.H. Takoma Pk Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 20, 1987
23c. NAME OF CEMETERY OR CREMATORY: Queen Chapel Cemetery
23d. LOCATION: CITY OR TOWN Beltsville COUNTY STATE Maryland

24. FUNERAL DIRECTOR NAME: A.S. Pope Funeral Home
ADDRESS: 2617 Pennsylvania Ave., SE, Washington, D.C.
25a. DATE REC'D. BY REGISTRAR: FEB 25 1987
25b. REGISTRAR'S SIGNATURE: Julia Dearborn-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, immediate report should be made.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

#14, G-625, 3/10/87, by F.H.
Gbj.

044527 FEB 1 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 32
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Roland MIDDLE LAST CAVATONI		2a. DATE OF DEATH MONTH DAY YEAR 02-15-87	2b. HOUR 9 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 07-14-32	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptrollar	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Defence

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Olney	YES ☐ NO ☐	18005 Overwood Dr. 20832

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
~~Tuccio~~	Tullio	Cavatoni	Maria		~~Parissenti~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes		200-24-4957	Joyce A. Cavatoni-wife-	(same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b)	WIDESPREAD METASTASES	10 MO
DUE TO, OR AS A CONSEQUENCE OF (c)	RENAL CELL CARCINOMA	10 MO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): LYMPHEDEMA & RADIATION BURN - LEFT ARM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/9, 19 87, to 2/15, 19 87, that (I) (we) last saw the deceased alive on 2/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Richard Delaney MD DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2/16/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD R. DELANEY MD 22e. ADDRESS 4323 HAVARD ST SILVER SPRING MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-19-1987	Parklawn Cemetery	Rockville Montgomery Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi Funeral Home	11800 N.H. Ave., Silver Spring, Md.	FEB 18 1987	Anna Dixon-Rudage

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 gives any injury or other traumatic event, the medical-legal section must be completed.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

045826 MD-3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05333

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eleanor MIDDLE: L. LAST: Chappell		2a. DATE OF DEATH MONTH DAY YEAR: Feb. 22, 1987	2b. HOUR: 8:30P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 30, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6104 Overlea Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Montgomery	Bethesda	YES ☒ NO ☐	6104 Overlea Road/20816

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Dominicus MIDDLE: -- LAST: Lindner	FIRST: Caroline MIDDLE: -- LAST: Freiermuth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	098-36-1390	Cynthia C. McClelland	Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Respiratory failure	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Cancer Metastasis - General	17 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Cancer of Left Breast	10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) [redacted] attended the deceased from June 10, 1972, to Feb. 22, 1987, that (I) (we) last saw the deceased alive on Feb. 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Samuel Diener, M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Samuel Diener	4201 Mass. Ave, NW, Washington, D.C. 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/26/87	Mt. Comfort Crematory	Alexandria, VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc.	5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 27 1987	[illegible]

044036 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 05334
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST HSIU MIDDLE LIEN LAST CHEN
HSIU LIEN CHEN

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 7 YEAR 1987
2b. HOUR 2050 M

3. SEX: Female
4. RACE: Asian
5. DATE OF BIRTH: MONTH 6 DAY 29 YEAR 87
6. AGE (IN YEARS LAST BIRTHDAY): 99 YRS.
IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 7 YEAR 1987
2d. HOUR 2050 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): China
7b. CITIZEN OF WHAT COUNTRY: China
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County

10. CITY OR TOWN OF DEATH: ROCKVILLE
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10903 TROY RD
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: ROCKVILLE
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS: 10903 TROY RD 20852

14. FATHER'S NAME FIRST Pang MIDDLE LAST Tseng
15. MOTHER'S MAIDEN NAME FIRST Duek MIDDLE LAST Pang

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 219-32-1609D
17. INFORMANT: Hopie Woodland
ADDRESS: 423 80th Street Ocean Marathon, Florida 33050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INDEF
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —
20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR 2050 A.M. P.M. MONTH 2 DAY 7 YEAR 1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): COLLAPSED AT HOME
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME
21f. LOCATION STREET 10903 TROY RD CITY OR TOWN ROCKVILLE COUNTY MONT. STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): DEPT MEDICAL EXAMINER DATE SIGNED: 2-7-87

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MAYUE ADDRESS: 8200 WISCONSIN AVE BETHESDA MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/14/87
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION CITY OR TOWN: Baltimore COUNTY STATE: Maryland

24. FUNERAL DIRECTOR: Leroy M. & Russell C. Witzke Funeral Homes P.A.
ADDRESS: 1630 Edmondson Avenue, Catonsville, MD. 21228
25a. DATE REC'D. BY REGISTRAR: FEB 13 1987
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE CAUSE OF DEATH SECTION. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP____ DHMH - 17 (VR A15 ME (5))

045727 MAR -3 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05335

1. DECEASED NAME (TYPE OR PRINT): FIRST LILLIAN MIDDLE S LAST CHESES

2a. DATE OF DEATH: MONTH 2 DAY 26 YEAR 87

2b. HOUR 9:05 A.M.

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH 9 DAY 15 YEAR 92

6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Russia

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auditor (Ret.)

12b. KIND OF BUSINESS OR INDUSTRY: R.E. Management

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 6111 Montrose Road (20852)

14. FATHER'S NAME: FIRST Samuel MIDDLE LAST Stolper

15. MOTHER'S MAIDEN NAME: FIRST Rose MIDDLE LAST (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): ------

16b. SOCIAL SECURITY NO.: 029-16-0400

17. INFORMANT: Dorothy Stein; Daughter; 13260 Country Ridge Dr. ADDRESS Germantown, Md. 20874

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiopulmonary arrest	10 min
DUE TO, OR AS A CONSEQUENCE OF (b)	systemic toxemia	48 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Gangrene left thigh, leg + foot	40 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: Jan 17 1987

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: False Aneurysm (L) groin

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 17 19 87, to Feb 25 19 87, that (I) (we) last saw the deceased alive on Feb 25 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE: Hugh H. Trout III MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 26 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Hugh H. Trout III

22e. ADDRESS: 8218 Wisconsin Ave Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3/1/87

23c. NAME OF CEMETERY OR CREMATORY: Poali Zedeck Cemetery

23d. LOCATION: CITY OR TOWN Everett, Massachusetts / COUNTY / STATE

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEM. CHAPELS
ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Dendson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the [illegible] and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re[illegible] papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cre[illegible]

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

043712 FEB 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 05356
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSE MIDDLE: LAST: CIANFARO		2a. DATE OF DEATH MONTH DAY YEAR: FEB. 5, 1987	2b. HOUR: 1748 M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: April 18, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 12716 War Admiral Way / 20878
14. FATHER'S NAME FIRST: John MIDDLE: Anthony LAST: Salamone		15. MOTHER'S MAIDEN NAME FIRST: Maria MIDDLE: LAST: Palma	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 168-16-8711	17. INFORMANT: Mr. Lawrence F. Signora, Son, Same as #13 — ADDRESS:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK	8 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC CARDIOMYOPATHY	5 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) PRIOR MYOCARDIAL INFARCTION	8 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES. RHEUMATIC HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/8, 1985, to 2/5, 1987, that (I) (we) last saw the deceased alive on 2/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GREGORIO ROYS MD	22e. ADDRESS: 15225 SHADY GROVE RD. ROCKVILLE MD 20850	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 10, 1987	23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Yeadon, Pennsylvania
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Ave. Rockville, Maryland 20850		25a. DATE REC'D. BY REGISTRAR: FEB 9 1987	25b. REGISTRAR'S SIGNATURE: Julia Bridgers Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

046511 MAR 0

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05337
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANN MIDDLE: LAST: CISENFELD

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 26, 1987

2b. HOUR: 8:35AM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH MONTH DAY YEAR: JULY 12, 1888

6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: ROCKVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT ABBREVIATE; GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALESLADY

12b. KIND OF BUSINESS OR INDUSTRY: CONCESSION STAND

12c. USUAL RESIDENCE (IF NOT IN HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: DISTRICT OF COLUMBIA

13b. COUNTY: none

13c. CITY OR TOWN: WASHINGTON

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS / ZIP CODE: 6323 LUZON AVENUE, N. W. 20011 99999

14. FATHER'S NAME FIRST: CHARLES MIDDLE: LAST: CISENFELD

15. MOTHER'S MAIDEN NAME FIRST: TOBIE MIDDLE: LAST: GREENFIELD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-07-9532

17. INFORMANT: HARRY CISENFELD, 815 THAYER AVENUE, ADDRESS: SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-24-86, 19, to 2-26, 19 87, that (I) (we) last saw the deceased alive on 2-26, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip Schwartz DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2-26-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PHILIP SCHWARTZ

22e. ADDRESS: 15225 Shady Grove Rd #206 Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL: BURIAL

23b. DATE: 3/1/1987

23c. NAME OF CEMETERY OR CREMATORY: ROSEDALE CEMETERY

23d. LOCATION CITY OR TOWN COUNTY STATE: BALTIMORE, BALTIMORE, MARYLAND

24a. FUNERAL DIRECTOR: DONALD N. STEIN HEBREW MEMORIAL FUNERAL HOME

24b. ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Anderson Rudolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. In the event the medical examiner must be notified, the medical examiner must be notified immediately.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified immediately.

BP 999999

DHMH - 16 60M 7/84 (VRA 15-4)

0'44893

FEB 23 '87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05338

1. DECEASED NAME (TYPE OR PRINT) FIRST: Paul MIDDLE: Joseph LAST: Clark		2a. DATE OF DEATH MONTH DAY YEAR: Feb 15 1987	2b. HOUR: 0630 AM
3. SEX: Male	4. RACE: Cauc	5. DATE OF BIRTH MONTH DAY YEAR: Feb 08 1921	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass. USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.
10. CITY OR TOWN OF DEATH: Bethesda, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Naval Hospital, Bethesda	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: US Navy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Calvert	Lusby	YES [ ] NO [X]	Box 53 Olivet Rd. 20657

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harry	Ross	Clark	Ida	Veronica	Langley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1941-1960	019-14-2943	Alice Audrey Clark	Box 53 Olivet Rd, Lusby, Md. 20657

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac and Renal Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Post-operative Sepsis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
16 Dec, 1986	Colon Cancer	YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1 JAN. 19 87 to 15 Feb 19 87 that (I) (we) last saw the deceased alive on 15 Feb 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Harry F. Meyers	MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	15 FEB 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Harry F. MEYERS

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-1987	Arlington National	Arlington, Fargo, Virginia

24. FUNERAL DIRECTOR NAME: Donald V. Borgwardt ADDRESS: Rt 264, Box 34B, Port Republic, Maryland 20676

25a. DATE REC'D. BY REGISTRAR: FEB 19 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rankes

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

144376 FEB 17 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 053 37
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lillie MIDDLE: L LAST: Cleaver

2a. DATE OF DEATH MONTH DAY YEAR: 02 11 '87

2b. HOUR: 9 10 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Feb. 4 1900

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 4970 Battery Lane 20814

14. FATHER'S NAME FIRST: Theodore MIDDLE / LAST: Lohman

15. MOTHER'S MAIDEN NAME FIRST: Elizabeth MIDDLE / LAST: Reifice

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214 36 1982

17. INFORMANT NAME / ADDRESS: 12520 Galway Dr. S.S.Md. Carol Seipel (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	4 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral Vascular Accident	4 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerosis	greater than 1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/7, 19 87, to 2/11, 19 87, that (I) (we) last saw the deceased alive on 2/11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark Kanovsky

DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/11/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN S. KANOVSKY

22e. ADDRESS: 5401 Western Ave, N.W. Washington DC 20015

23a. BURIAL, CREMATION, REMOVAL: Burial

23b. DATE: 2/13/87

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, Va.

24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S.Md.

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

45758 MAR -3 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05340
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Beulah MIDDLE: A. LAST: Cole

2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1987

2b. HOUR: 4:30p.m

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: Nov. 9 1903

6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colonial Villa Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: Gleneagles Drive 20906

14. FATHER'S NAME FIRST: James MIDDLE LAST: Arnett

15. MOTHER'S MAIDEN NAME FIRST: Margaret MIDDLE LAST: Patrick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-26-0168

17. INFORMANT: brother Boyd Arnett ADDRESS: 12711 Two Farm Dr. Silver Spring, Md. 20904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 7 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I (this hospital) attended the deceased from Aug. 19 87 to Feb. 19 87 that (I (we) last saw the deceased alive on Feb 19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.

22b. SIGNATURE: M D DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 19 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Leibowitz, M.D.

22e. ADDRESS: 11120 N. Hampshire Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23, 1987

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Brentwood Prince Georges Md.

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd. West, Silver Spring, Md.

26a. DATE RECD. BY REGISTRAR: MAR 02 1987

26b. REGISTRAR'S SIGNATURE: Julia Dandridge-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or toxic event, the medical examiner must be notified immediately.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045261 FEB 26 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 41
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Leslie MIDDLE Burt LAST Colfix

2a. DATE OF DEATH: MONTH February DAY 19 YEAR 1987

2b. HOUR: 6 P.M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH Nov. DAY 23 YEAR 1901

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): So. Dakota

7b. CITIZEN OF WHAT COUNTRY?: U S A

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ALTHEA WOODLAND Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Comptroller-

12b. KIND OF BUSINESS OR INDUSTRY: General Mills

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY:

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 904 New Hampshire Ave. N.W. 99999

14. FATHER'S NAME: FIRST Louis MIDDLE J. LAST Colfix

15. MOTHER'S MAIDEN NAME: FIRST Lydia MIDDLE S. LAST Burt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 441-01-7015

17. INFORMANT: Dolores C. Rechel — ADDRESS: Same as items #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute Bronchitis

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from June 86 to 19 Feb 19 87, that (we) last saw the deceased alive on 19 Feb 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Merton L White MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 19 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Merton L. WHITE, M.D.

22e. ADDRESS: 9911 Georgia Ave Silver Spring, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/20/87

23c. NAME OF CEMETERY OR CREMATORY: B/W Crematory

23d. LOCATION: CITY OR TOWN: Laurel, COUNTY: P. G. Co., STATE: Md.

24. FUNERAL DIRECTOR: NAME: Takoma Funeral Home-Washington, D.C. ADDRESS: 254 Carroll St. NW,

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Bankson-Cadeau

BP 999999

DHMH - 1650M 4/83 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked "Yes", the medical examiner must be notified. Page 4 may be released by Dr. Rogers, Medical Examiner

10

45184 FEB 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have certificate signed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05342

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CATHERINE S. COLEMAN			2a. DATE OF DEATH MONTH DAY YEAR: 2-19-87	2b. HOUR: 9:51 AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 2 02 12	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Rockville	YES [X] NO [ ]	5200 Yosemite Drive/20853

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Harry / Schiefer	Mary / Portz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		172-18-9095	Harold Coleman, Same as #13.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive heart failure	3d
DUE TO, OR AS A CONSEQUENCE OF (b)	rheumatic heart disease	2 decades
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): diabetes mellitus, acute liver failure (secondary to 1b), acute renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from July, 1983, to Feb 19, 1987, that (I) (~~we~~) last saw the deceased alive on Feb 19, 1987, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Michael Lincoln MD	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL LINCOLN, M.D.	10313 Georgia Ave Silver Spring Md. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 23, 1987	Arlington National	Arlington / Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc 300 West Montgomery Avenue Rockville, Maryland 20850	FEB 24 1987	Julia Davidson-Pendergast

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

Item 3 3/2/87 jab

16 B. Film 6625

043910 FEB 13 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053443
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: IRENE MIDDLE: LAST: Colston		2a. DATE OF DEATH MONTH 2 DAY 7 YEAR 87	2b. HOUR 4:15 pm
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH 9 DAY 17 YEAR 1894	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash.D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE NAME, NOT NUMBER OR STREET): Bethesda Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Clerk-Retired	12b. KIND OF BUSINESS OR INDUSTRY: G.A.O.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: C.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 7400 Western Ave 20815

14. FATHER'S NAME FIRST: Henry MIDDLE: LAST: White	15. MOTHER'S MAIDEN NAME FIRST: Isabel MIDDLE: LAST: Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: ~~577 09 1258~~ 216-46-9086	17. INFORMANT: 15115 Interlachen Dr.S.S.Md. Peter McCluskey (Nephew)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest.	Stat.
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial infarction	15 min
DUE TO, OR AS A CONSEQUENCE OF (c)	atherosclerosis	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 72, to Feb 7 19 87, that (I) (we) last saw the deceased alive on Jan 5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert S. Poole	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb 7.87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT S. POOLE	22e. ADDRESS: 4501 CONN. AVE. N.W DC 20008	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/11/87	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION CITY OR TOWN: Rockville STATE: Mont. Md.
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.		25a. DATE REC'D BY REGISTRAR: FEB 11 1987	25b. REGISTRAR'S SIGNATURE: Julia Bowden-Rendeen

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The local registrar must receive the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05344 REG. NO.

45448 FEB 27 8

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE A. C. LAST CONNELLY
2a. DATE OF DEATH: MONTH FEB. DAY 23, YEAR 1987
2b. HOUR: 6:30 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH MAY DAY 11, YEAR 1909
6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): LOUISIANA
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SPENCERVILLE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 16705 New Hampshire Ave.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE): Stat. Economist
12b. KIND OF BUSINESS OR INDUSTRY: U.S.GOV.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: MONT.
13c. CITY OR TOWN: SPENCERVILLE
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 16705 New Hampshire Ave. 20868

14. FATHER'S NAME: FIRST ALEXANDER MIDDLE R. LAST CONNELLY
15. MOTHER'S MAIDEN NAME: FIRST MARY MIDDLE J. LAST COLLIER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES
(IF YES, GIVE WAR OR DATES): W.W.II
16b. SOCIAL SECURITY NO.: 413-07-6195
17. INFORMANT: William A. Connelly
ADDRESS: 16709 New Hamp. Ave. Spencerville, Md. 20868

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver failure due to metastatic cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of pancreas — 8 mo
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May, 19 86, to 23 Feb, 19 87, that (I) (~~not~~ last saw the deceased alive on 7 Feb, 19 87, and that in (my) (~~our~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~ (~~did~~) (did not) view the body after death.
22b. SIGNATURE: Donald E. Dillon MD
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 23 Feb 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Donald E. Dillon
22e. ADDRESS: Olney, Md. 20832

23a. BURIAL, CREMATION, REMOVAL: CREMATION
23b. DATE: FEB.23,1987
23c. NAME OF CEMETERY OR CREMATORY: BALT.WASH. CREMATORY
23d. LOCATION: CITY OR TOWN LAUREL COUNTY P.GEORGE STATE MD.
24. FUNERAL DIRECTOR: NAME MURIEL H. BARBER ADDRESS LAYTONSVILLE, MD. 20879
25a. DATE REC'D BY REGISTRAR: FEB 26 1987
25b. REGISTRAR'S SIGNATURE: Julia Barbara Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the medical examiner's portion (Pages 1 and 2 should be filed within 72 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

043885 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 45
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Claudine MIDDLE: Agnew LAST: Cooper		2a. DATE OF DEATH MONTH DAY YEAR: FeBR. 7, 1987	2b. HOUR: 1:20PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 15, 1936	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4225 Brookfield Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Kensington	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 4225 Brookfield Road 20895

14. FATHER'S NAME FIRST: Troy	MIDDLE: Joseph	LAST: Agnew	15. MOTHER'S MAIDEN NAME FIRST: Wanda	MIDDLE: Louise	LAST: Bellman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-32-8168	17. INFORMANT: Sharon Cooper Fassbach, ADDRESS: 14357 Georgia Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST — 6 yrs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from — 19 81, to 2/7 19 87, that (I) (we) last saw the deceased alive on 2/7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did/did not) view the body after death.

22b. SIGNATURE: Richard H Pollen MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/7/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): RICHARD H. POLLEN, MD	22e. ADDRESS: 10400 Connecticut Ave KENSINGTON, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02-09-87	23c. NAME OF CEMETERY OR CREMATORY: George Washington Cem.	23d. LOCATION CITY OR TOWN, COUNTY, STATE: Adelphi, P.G., Maryland
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi Funeral Home, Inc. ADDRESS: 11800 New Hampshire Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 11 1987	25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completely filled in by the funeral director within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

045610 FEB 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to cremation, or removal. remove carbon papers.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 - 05340
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ARTHUR RICHARD CRANDALL		2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 19 1987	2b. HOUR: 11:02 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 3 1929	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
KENTUCKY	MCCRACKEN	PADUCAH	YES [X] NO [ ]	273 NAVAHO DRIVE 42001

14. FATHER'S NAME FIRST MIDDLE LAST: HOWARD EDWARD CRANDALL	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: IRENE BRENDETTA LUDLOW

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	1946-1967	097-22-1698	RUBY D.CRANDALL,273 NAVAHO DRIVE,PADUCAH,KY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 25, 19 87, to FEBRUARY 19, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Edward P. Fox	M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	20 Feb - 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EDWARD P. FOX, LT, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02/24/87	MAPLELAWN CEMETERY	PUDUCAH	MCCRACKEN	KY

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruth Funeral Chapel	433 Monroe St Paducah, Ky	FEB 26 1987	[illegible]

999999

BP 999

DHMH - 16 60M 7/84
(VRA 15, 4)

043715 FEB 11 87

FOR STATE REGISTRAR HELEN B. CREAGHAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05341

1. DECEASED NAME (TYPE OR PRINT) FIRST Helen MIDDLE B. LAST Creaghan			2a. DATE OF DEATH MONTH 2 DAY 4 YEAR 87	2b. HOUR 9:26 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH JAN. DAY 21, YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OR PRINT THE MOST LONG WORKING LIFE) OFFICE CLERK	12b. KIND OF BUSINESS OR INDUSTRY U.S. TREAS.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	MONT.	GAITHERSBURG	YES ☒ NO ☐	18602 Walkers Choice Rd. 20879

14. FATHER'S NAME FIRST ASHBY MIDDLE – LAST BROWN		15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE – LAST ROLLINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-32-3441	17. INFORMANT JAMES E. CREAGHAN	ADDRESS ~~9936 Brook Ridge Ct.~~ Gaithersburg, Md. 20879

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Adult respiratory distress Syndrome	3 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute hemorrhagic Pancreatitis	3 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic interstitial pneumonitis

19a. DATE OF OPERATION 1/30/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pancreatic pseud. cyst	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 19 87, to Feb 4, 19 87, that (I) (we) last saw the deceased alive on Feb 4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Michael A. Greene MD	DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Greene, MD	22e. ADDRESS 19642 Club House Rd, Gaithersburg, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY EBENEZER METH. CEM.	23d. LOCATION CITY OR TOWN CHASE / COUNTY BALTIMORE / STATE MD.
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR FEB 9 1987	25b. REGISTRAR'S SIGNATURE Julia Dudley Andrews

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR STATE REGISTRAR

MAR - 8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05348

1. DECEASED NAME (TYPE OR PRINT) FIRST: LEO MIDDLE: P LAST: CURLEY JR		2a. DATE OF DEATH MONTH DAY YEAR: 2 23 87	2b. HOUR: 1035 PM
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 1 - 31 - 13	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Police Officer	12b. KIND OF BUSINESS OR INDUSTRY: Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	Pr. Geo	Hyattsville	YES ☒ NO ☐	812 SHERIDAN STREET

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Leo	P.	Curley, Sr.	Margaret		Daley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	020-09-9928	Caroline McAllister	Hyattsville, Md 2078 812 Sheridan St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACute Respiratory Failure	6 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic Disease to Liver	2 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma of Pancreas	2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Obstructive Lung Disease; Osteoarthritis; Pyloric Ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/19, 1987, to 1/23, 1987, that (I) (~~we~~) last saw the deceased alive on 1/23, 1987, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Alfred Munzer	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Alfred Munzer M.D.	7600 Carroll Avenue Takoma Park, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 27 1987	St. Patricks Cem	Stoneham, Mass

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Homes	Arl, Va.	MAR 04 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, pc., should be detached for use as the burial-transit permit. Then please remove carbon paper, and file page 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Medical examiner must be notified of any IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any injury, or other traumatic event.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05349

0437 1 FEB 1 87

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: A. LAST: Curtis

2a. DATE OF DEATH MONTH DAY YEAR: February 5, 1987

2b. HOUR: M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: April 10, 1909

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Potomac

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9409 Reach Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Executive

12b. KIND OF BUSINESS OR INDUSTRY: Education Tele-Communi-cation

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Potomac

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 9409 Reach Road/ 20854

14. FATHER'S NAME FIRST: Osborn MIDDLE: LAST: Curtis

15. MOTHER'S MAIDEN NAME FIRST: Edna MIDDLE: LAST: Onderdonk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N.A.

16b. SOCIAL SECURITY NO.: 067-07-1845

17. INFORMANT (Wife) ADDRESS: 9409 Reach Road Bettina Jones Curtis, Potomac, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Uncontrolled Squamous Cell Carcinoma of the Base of Tongue — One Year

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/9 19 86 to 2/5 19 87, that (I) (we) last saw the deceased alive on 11/4 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Christine D. Berg, M.D. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: February 6, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Christine D. Berg, M.D.

22e. ADDRESS: 9711 Medical Center Dr., Rockville, Maryland 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 9, 1987

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial

23d. LOCATION CITY OR TOWN: Rockville COUNTY STATE: Maryland

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home ADDRESS: Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 9 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson Pardee

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045994 MAR -4 0

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 05350
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Sophia MIDDLE LAST Crwsor

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Feb DAY 23 YEAR 1987 — 2b. HOUR 1147 A.M. P.M.

3. SEX: F — 4. RACE: Blk — 5. DATE OF BIRTH: MONTH April DAY 22 YEAR 1890 — 6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. — IF UNDER 1 YR.: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 23 YEAR 1987 — 2d. HOUR 1147 A.M. P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. — 7b. CITIZEN OF WHAT COUNTRY? United States — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Tak Park — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash Adventist Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: N. Brentwood — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 3904 Webster Street

20783

14. FATHER'S NAME: FIRST JoHn MIDDLE LAST Johnson — 15. MOTHER'S MAIDEN NAME: FIRST Kate MIDDLE LAST Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 577-16-0845 — 17. INFORMANT: Johnetta Jackson Granddaughter/ — ADDRESS: 5300 Varnum Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Dis.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED Feb 24 1987

EXAMINER'S NAME (TYPE OR PRINT) ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 27Feb 87 — 23c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem. Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Frazier's Funeral Home 389 Rhode Island Avenue. — 25a. DATE REC'D. BY REGISTRAR: MAR 03 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Dickson Rendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

044575 FEB 19 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 51
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Arthur Hampar Dadian		2a. DATE OF DEATH MONTH DAY YEAR: February 14, 1987	2b. HOUR: 1:00p M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 27,1909	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Turkey	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4952 Sentinel Drive (Residence)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Lawyer	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS / ZIP CODE: 4952 Sentinel Drive / 20816

14. FATHER'S NAME FIRST / MIDDLE / LAST: Hampar None Dadian		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Veronica None Kassardjian	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-52-3022	17. INFORMANT ADDRESS: Marjorie M. Dadian(Wife) Same As #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Prostate Cancer — 3 Years

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from October 1, 19 85, to February 14, 19 87, that (I) (we) last saw the deceased alive on February 10, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas Sacks	DEGREE: MD	ATTENDING PHYSICIAN X / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb. 14,1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr Thomas Sacks MD		22e. ADDRESS: 2201 L Street N.W. Washington D.C. 20037	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.18,1987	23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington D.C.
24. FUNERAL DIRECTOR NAME: Robert A. DeVol	ADDRESS: DeVol Funeral Home, INC. 2222 Wis. Ave. N.W. Wash. D.C	25a. DATE REC'D BY REGISTRAR: FEB 18 1987	25b. REGISTRAR'S SIGNATURE: Julia Dawson Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 / 05352

0441 15 FEB 1987

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: BLANCHE M. DAHMER		2a. DATE OF DEATH MONTH DAY YEAR: FEB. 4, 1987	2b. HOUR: 7:10A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: June 16, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH: KENSINGTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CIRCLE MANOR NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker	12b. KIND OF BUSINESS OR INDUSTRY: Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: College Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 9719-51St. Ave. /20740
14. FATHER'S NAME FIRST / MIDDLE / LAST: Russel - Strippy		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Elizabeth - Powers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: 579-12-2801	17. INFORMANT: Mr. Roland L. Dahmer — ADDRESS: 543 Wilson Bridge Dr. Oxon Hill Md. 20745

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: INSTANT

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE — 4 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC ORGANIC BRAIN SYNDROME W/DEMENTIA

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 19 86, to Feb 4, 19 87, that I (we) last saw the deceased alive on 12/31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin C Shargel — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN C SHARGEL — 22e. ADDRESS: 3220 FARRAGUT AVE. KENSINGTON, MD 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY: National Mem. Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Fairfax / Virginia
24. FUNERAL DIRECTOR NAME: W.W. Chambers Co. Inc. — ADDRESS: 5801 Cleveland Ave Riverdale Md 20737		25a. DATE REC'D BY REGISTRAR: FEB 13 1987	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

043944 FEB 13 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 055555
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: GORDON WAYNE DASHER, SR.		2a. DATE OF DEATH MONTH DAY YEAR: 2/4/87	2b. HOUR: 10:17 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 29, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Private Industry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 712 Cabin John Parkway 20852

14. FATHER'S NAME FIRST: Francis	MIDDLE: Wagner	LAST: Dasher	15. MOTHER'S MAIDEN NAME FIRST: Margaret	MIDDLE: Haines — LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 260-09-9119	17. INFORMANT: Mary S. Dasher (wife) — ADDRESS: same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOR MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 87, to 2/4 19 87, that (I) (we) last saw the deceased alive on 2/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Barry S Talesnick MD	DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]		22c. DATE SIGNED: 2/4/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY S TALESNICK MD		22e. ADDRESS: 9711 Medical Center Drive Rockville Maryland 20853	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/9/87	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park	23d. LOCATION CITY OR TOWN — COUNTY — STATE: Rockville, Maryland
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. — ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR: FEB 11 1987	25b. REGISTRAR'S SIGNATURE: Alia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05554

044041 FEB 17 87

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Gad — MIDDLE: — LAST: Degraphenreid

2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ — MONTH DAY YEAR: Feb 5, 1987

2b. HOUR: 8:58 A.M.

3. SEX: M

4. RACE: Blk

5. DATE OF BIRTH — MONTH DAY YEAR: June 16, 1910

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.

IF UNDER 1 YR. — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.:

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: Feb 1987

2d. HOUR: 9:14 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery Gen'l Hosp. EQUIP Oter

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): EQUIP Oter

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Montg.

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 16000 Avery Rd. / 20855

14. FATHER'S NAME — FIRST: Charlie — MIDDLE: Degraphereid — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Margie — MIDDLE: ? — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 240-16-4640

17. INFORMANT: Evelyn Degraphenreid (wife) — ADDRESS: same AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured Thoracic Aortic Aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep. — MEDICAL EXAMINER — DATE SIGNED: Feb 5 1987

EXAMINER'S NAME (TYPE OR PRINT): — ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 2-9-87

23c. NAME OF CEMETERY OR CREMATORY: Allen Assoc. Mortuary

23d. LOCATION — CITY OR TOWN: Ashville, N. C. — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME: George R. Snowden — ADDRESS: 246 N. Washington St. Rockville, MD 20850

25a. DATE REC'D BY REGISTRAR: FEB 11 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PARTS 18 AND 19. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

044147 FEB 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05355

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rene MIDDLE: LAST: Della Torre		2a. DATE OF DEATH MONTH DAY YEAR: February 9, 1987	2b. HOUR: 10:29 A.M.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 27, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Banking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Rockville	YES ☒ NO ☐	6111 Montrose Road/20852

14. FATHER'S NAME FIRST: Rodolfo MIDDLE: LAST: Della Torre		15. MOTHER'S MAIDEN NAME FIRST: Regina MIDDLE: LAST: Coen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 089-16-6077	17. INFORMANT: Edward Della Torre ADDRESS: 9603 Alta Vista Terr. Bethesda, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cardiac Arrest - Pulmonary Arrest	sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Advanced diffuse pulmonary fibrosis	15 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (~~XXXXXX~~) attended the deceased from October 13, 19 82, to December 10, 19 86, that (I) (~~X~~) last saw the deceased alive on December 10, 19 86, and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~XXXX~~ did not) view the body after death.

22b. SIGNATURE: Daniel J. Esposito	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb. 11, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel J. Esposito, M.D.		22e. ADDRESS: 5454 Wisconsin Avenue Chevy Chase, MD 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crem.	23d. LOCATION CITY OR TOWN COUNTY STATE: Alexandria, Virginia
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814		25a. DATE REC'D. BY REGISTRAR: FEB 17 1987	25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

CLEARED BY DR TAUBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05356
REG. NO.

45438

1. DECEASED NAME (TYPE OR PRINT): FIRST Holmes MIDDLE W. LAST DeVall
Holmes DeVall

2a. DATE KNOWN OF DEATH ESTIMATED: MONTH Feb DAY 24 YEAR 1987 — 2b. HOUR 1015 A.M.

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH 12 DAY 5 YEAR 14 — 6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 24 YEAR 1987 — 2d. HOUR 1015 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Sil Spg. — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Wash.Gas.Co. — 12b. KIND OF BUSINESS OR INDUSTRY: Foreman

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Sil Spg — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 13208 Glenhill Rd.

14. FATHER'S NAME: FIRST Alpheus MIDDLE W. LAST DeVall — 15. MOTHER'S MAIDEN NAME: FIRST Eleanor MIDDLE LAST Beotner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 577 03 8592 — 17. INFORMANT: Laura E. DeVall (Wife) ADDRESS: Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Berg MEDICAL EXAMINER — DATE SIGNED Feb 24 1987

EXAMINER'S NAME (TYPE OR PRINT) Dr.John S. Rogers ADDRESS 1919 Seminary Rd.S.S.Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/27/87 — 23c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln — 23d. LOCATION CITY OR TOWN: Brentwood COUNTY: PG STATE: Md.

24. FUNERAL DIRECTOR NAME: Hines/Rinaldi ADDRESS: 11800 New Hamp.Ave.S.S.Md. — 25a. DATE REC'D. BY REGISTRAR: FEB 26 1987 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

045247 FEB 2 0 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05351
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST WILLIAM; MIDDLE; LAST DEVINE, JR.

2a. DATE OF DEATH (MONTH DAY YEAR): 02/17/87

2b. HOUR: 1:15 A.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH (MONTH DAY YEAR): May 13, 1920

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 16400 South Westland Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Production engineer

12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Energy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 16400 South Westland Drive 20877

14. FATHER'S NAME: FIRST William; MIDDLE; LAST Devine

15. MOTHER'S MAIDEN NAME: FIRST Sarah; MIDDLE; LAST Haworth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 026-12-9230

17. INFORMANT: Chloe J. Devine, ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Adenocarcinomatosis, Prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia, Neuromyopathy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from — 19 79, to 17 Feb 19 87, that (I) (we) last saw the deceased alive on 23 Sept 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Donald E. Dillon MD — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 17 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Donald E. Dillon, M.D.

22e. ADDRESS: 2901 Olney-Sandy Spring Rd. Olney, MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-17-87

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION: CITY OR TOWN; COUNTY; STATE: Alexandria, Virginia

24. FUNERAL DIRECTOR: NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Bandon-Lindsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

045955 MAR 4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05358
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BETTY MIDDLE: C. LAST: DAVIS

2a. DATE OF DEATH MONTH DAY YEAR: 02 28 87

2b. HOUR: 1330 M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH MONTH DAY YEAR: May 16 31

6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Mont MD.

10. CITY OR TOWN OF DEATH: Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Group Leader

12b. KIND OF BUSINESS OR INDUSTRY: Wash. Hosp. Ctr.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: PG

13c. CITY OR TOWN: Hyattsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 6102 Balfour Drive 20782

14. FATHER'S NAME FIRST: Daniel MIDDLE: LAST: Walker

15. MOTHER'S MAIDEN NAME FIRST: Azalee MIDDLE: LAST: Calloway

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 230-42-6528

17. INFORMANT: Ms. Hurshell Y. Davis/daughter/same as 13e ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lungs c Mets to Brain. + Bones

DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertension, Pancreatitis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/24/ 19 87 to 2/28/ 19 87, that (I) (we) last saw the deceased alive on 2/27/ 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): VIVEK C VAID

22e. ADDRESS: 3311 Toledo Terrace Hyattsville Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3-4-87

23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem. Park

23d. LOCATION CITY OR TOWN COUNTY STATE: Landover, Md.

24. FUNERAL DIRECTOR NAME ADDRESS: John T. Rhines Co., 3015 12th St. N.E., D.C. 20017

25a. DATE REC'D. BY REGISTRAR: MAR 03 1987

25b. REGISTRAR'S SIGNATURE: Julia Gordon-Anderson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

1

046286 MAR - 01 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05359
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST EDNA MIDDLE E LAST DAVIS

2a. DATE OF DEATH: MONTH 02 DAY 28 YEAR 87

2b. HOUR: 2:10p.m

3. SEX: FEMALE

4. RACE: CAUC

5. DATE OF BIRTH: MONTH 03 DAY 02 YEAR 23

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2600 Randolph Rd. 20902

14. FATHER'S NAME: FIRST Earl MIDDLE Bryant LAST Webb

15. MOTHER'S MAIDEN NAME: FIRST Wesley MIDDLE Katherine LAST Hinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-22-3769

17. INFORMANT: Leonard J. Davis, Sr. husband — ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary Embolus

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO X

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (Describe injury in Item 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 2/28 19 87 to 2/28 19 87 that I (we) last saw the deceased alive on 2/28 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark H. Eig MD — DEGREE: ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 3/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS: 9801 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: March 4, 1987

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cem.

23d. LOCATION (CITY OR TOWN, COUNTY, STATE): Adelphi Prince Georges Md.

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr.
ADDRESS: 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D BY REGISTRAR: MAR 06 1987

25b. REGISTRAR'S SIGNATURE: Julia Stinson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, medical examiner must be notified of death.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045857 MAR - 1 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05360

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Raymond MIDDLE F. LAST DAY		2a. DATE OF DEATH MONTH DAY YEAR Feb. 25, 1987	2b. HOUR 9:30 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 26,1906	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmaster	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Monrovia	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE 12635 Fingerboard Rd. 21770

14. FATHER'S NAME FIRST James	MIDDLE Start	LAST Day	15. MOTHER'S MAIDEN NAME FIRST Laura	MIDDLE Helen / LAST Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 218-32-3338	17. INFORMANT Annie S. Day,	ADDRESS Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — 2/25/87

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/25 19 87, to 2/25 19 87, that (I) (we) last saw the deceased alive on 2/25 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] MD	DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lodmell, M.D.	22e. ADDRESS 2901 Olney-Sandy Spring Rd., Olney, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb.28,1987	23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.	23d. LOCATION CITY OR TOWN Browningsville, COUNTY Montg., STATE Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR MAR 02 1987	25b. REGISTRAR'S SIGNATURE [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after d... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 05361

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Salvadora MIDDLE: Debayle LAST: de Somoza

2a. DATE OF DEATH — MONTH DAY YEAR: Feb. 17, 1987

2b. HOUR: 2:45P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: May 27, 1894

6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Nicaragua

7b. CITIZEN OF WHAT COUNTRY?: Nicaragua

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Potomac

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 13300 River Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Potomac

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 13300 River Road/20854

14. FATHER'S NAME — FIRST: Luis MIDDLE: H. LAST: Debayle

15. MOTHER'S MAIDEN NAME — FIRST: Casimira MIDDLE: -- LAST: Sacasa

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ---

16b. SOCIAL SECURITY NO.: N/A

17. INFORMANT — ADDRESS: Mrs. Guillermo Sevilla-Sacasa, Same address as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary Sclerosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-29, 19 67, to 2-17, 19 87, that (I) (we) last saw the deceased alive on 2-13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Louis Ross, M.D. DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/17/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Louis Ross

22e. ADDRESS: 5100 Wis. Ave, NW, Washington, D.C. 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/20/87

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.

23d. LOCATION — CITY OR TOWN COUNTY STATE: Silver Spring, MD

24. FUNERAL DIRECTOR — NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016

25a. DATE RECD. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE: Julia Dickerson Lindsay

045144 FEB 26 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 / 05362

1. DECEASED NAME (TYPE OR PRINT) FIRST Michael MIDDLE Thomas LAST DieVart
MICHAEL DIEVART

2a. DATE OF DEATH MONTH FEB. DAY 20 YEAR 1987
2b. HOUR 1417 PM

3. SEX Male
4. RACE White
5. DATE OF BIRTH MONTH June DAY 20 YEAR 1957
6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? United States
8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.

10. CITY OR TOWN OF DEATH Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housing specialist
12b. KIND OF BUSINESS OR INDUSTRY Gov't Contractor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland
13b. COUNTY Montgomery
13c. CITY OR TOWN Gaithersburg
13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS / ZIP CODE 10089 Maple Leaf Drive / 20879

14. FATHER'S NAME FIRST Francis MIDDLE J. LAST DieVart
15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE M. LAST Gibbons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 203-46-1989
17. INFORMANT William J. Stinson, ADDRESS Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACQUIRED IMMUNODEFICIENCY SYNDROME
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ✓
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/1 1985 to 2/20 1987, that (I) (we) last saw the deceased alive on 2/20 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE Ralph Coan DEGREE
ATTENDING PHYSICIAN ✓ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED 2/21/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH COAN MD
22e. ADDRESS 4400 EAST WEST HWY BETHESDA, Md. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation
23b. DATE 2-21-87
23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory
23d. LOCATION CITY OR TOWN Alexandria, COUNTY STATE Virginia

24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009
25a. DATE REC'D. BY REGISTRAR FEB 25 1987
25b. REGISTRAR'S SIGNATURE Julia Dickson Rudisill

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

045004 FEB 25 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 05303
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Joseph MIDDLE K. LAST D'Iorio

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐: MONTH Feb DAY 12 YEAR 19 87 — 2b. HOUR 1:40 P.M.

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH Dec DAY 13 YEAR 19 19 — 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 12 YEAR 19 87 — HOUR 6:35 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Sil. Spg — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Printer — 12b. KIND OF BUSINESS OR INDUSTRY: Commerce Dept.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Sil Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 10508 Marlone St. 20902

14. FATHER'S NAME: FIRST Salvatore MIDDLE LAST D'Iorio — 15. MOTHER'S MAIDEN NAME: FIRST Catherine MIDDLE LAST McKeon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): W.W. II — 16b. SOCIAL SECURITY NO.: 080-12-6130 — 17. INFORMANT: Dorothea E. D'Iorio wife — ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Dis. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Myocardial Dis — 4 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 12 1987

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial — 23b. DATE: Feb. 17, 1987 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery — 23d. LOCATION: CITY OR TOWN Silver Spring, COUNTY Montgomery, STATE Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. — ADDRESS 500 University Blvd. West, Silver Spring, Md. — 25a. DATE RECEIVED BY REGISTRAR FEB 20 1987 — 25b. [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A) 5 ME (5))

046463 MAR 10 0

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05304
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SARAH MIDDLE: LAST: DOLINKA		2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 28 1987	2b. HOUR: 4:30A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 16 1899	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): RUSSIA	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH: KENSINGTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): KENSINGTON GARDENS NURSING HOME	12a. USUAL OCCUPATION (IF RETIRED, LAST OCCUPATION WORKING LIFE): SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY: CLOTHING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: KENSINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 3000 McCOMAS AVENUE, 20895

14. FATHER'S NAME FIRST MIDDLE LAST: (UNASCERTAINABLE) (UNASCERTAINABLE)	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: (UNASCERTAINABLE) (UNASCERTAINABLE)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 110-12-5284A	17. INFORMANT ADDRESS: MILTON DOLINKA, 1209 DOWNS DRIVE, SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) DEMENTIA ORGANIC BRAIN SYNDROME.

DUE TO, OR AS A CONSEQUENCE OF (b) SIDEROBLASTIC ANEMIA.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kaldun Nossuli MD — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. A. KALDUN NOSSULI, M. D.	22e. ADDRESS: 11500 OLD GEORGETOWN ROAD ROCKVILLE, MARYLAND	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 3/3/1987	23c. NAME OF CEMETERY OR CREMATORY: WELLWOOD CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE: FARMINGDALE, LONG ISLAND, N. Y.
24. FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR: MAR 04 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpaper pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. In the medical examiner's case, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

045005 F02

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 05303
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Hettie MIDDLE: M. LAST: Domm		2a. DATE OF DEATH MONTH DAY YEAR: 2-13-87	2b. HOUR: 8:35 P.M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 11 24 1890	6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.
10. CITY OR TOWN OF DEATH: Sandy Spring, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Friends Nsg. Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Girl's Dorm Mother	12b. KIND OF BUSINESS OR INDUSTRY: North Central Coll.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sandy Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 17310 Quaker Ln. 20860

14. FATHER'S NAME FIRST: Jacob MIDDLE: LAST: Lint		15. MOTHER'S MAIDEN NAME FIRST: Caroline MIDDLE: LAST: Sitter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 346-28-6919	17. INFORMANT: son Dr. Sheldon Domm ADDRESS: 5104 Jacksboro Pike Knoxville, Tenn. 37918

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	2 wk
DUE TO, OR AS A CONSEQUENCE OF (b)	Alzheimers Disease	4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Cardiovascular	years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/12, 19 87, to 2/13, 19 87, that (I) (we) last saw the deceased alive on 2/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): [illegible] MD		22e. ADDRESS: 1811 Bx Philip Dr, Olney Md 20832	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/15/87	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria, Virginia
24. FUNERAL DIRECTOR: Francis J. Collins, Jr.	ADDRESS: 500 University Blvd. W., Silver Spring, Md. 20901	25a. DATE REC'D. BY REGISTRAR: FEB 20 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rawlings

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Case withdrawn Examiner

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

044201 FEB

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 05300
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Okey MIDDLE Earl LAST Butson

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐: MONTH Feb DAY 9 YEAR 19 87 — 2b. HOUR 12 P.M.

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH Sept DAY 18 YEAR 21 — 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 9 YEAR 19 87 — 2d. HOUR 1:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): 9

7b. CITIZEN OF WHAT COUNTRY?: 30

8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Sil. Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8652 Piney Branch Rd Apt 104

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): 35

12b. KIND OF BUSINESS OR INDUSTRY: 35

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Sil. Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 8652 Piney Branch Rd Apt 104 — 22901

14. FATHER'S NAME: FIRST / MIDDLE / LAST — 35

15. MOTHER'S MAIDEN NAME: FIRST / MIDDLE / LAST — 35

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES) — 1

16b. SOCIAL SECURITY NO.: 234-20-2404

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Malnutrition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY) Dep — MEDICAL EXAMINER — DATE SIGNED Feb 9, 1987

EXAMINER'S NAME (TYPE OR PRINT) — ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) — 23b. DATE — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION: CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR: NAME / ADDRESS

25a. DATE REC'D BY REGISTRAR: FEB 11 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05361

043300 FEB-9

1. DECEASED NAME (TYPE OR PRINT): FIRST Regis MIDDLE F. LAST Dougherty
2a. DATE OF DEATH: MONTH 2 DAY 2 YEAR 87
2b. HOUR 8:25 AM
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH 7 DAY 15 YEAR 08
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co., MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Printer
12b. KIND OF BUSINESS OR INDUSTRY: Printing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 7101 Clarendon Road #2 20814

14. FATHER'S NAME: FIRST Luke MIDDLE Joseph LAST Dougherty
15. MOTHER'S MAIDEN NAME: FIRST Catherine MIDDLE LAST Coyne
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-01-4253
17. INFORMANT: Francis R. Dougherty son ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Severe renal failure
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/2/87 19 to 2/2/87 19 that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. D. Khianey
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): HIRU D. KHIANEY
22e. ADDRESS: 20428 Germantown Road, Germantown, Maryland 20874

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 4, 1987
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION: CITY OR TOWN Silver Spring COUNTY STATE Maryland

24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.
ADDRESS: 7557 Wisconsin Ave. Bethesda, Maryland 20814
25a. DATE REC'D. BY REGISTRAR: FEB 5 1987
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The information that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Those remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Vital Records, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or [illegible] cremation, or removal.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05 08

REG. NO.

043148

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Papers 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: Olivia LAST: Doxzen			2a. DATE OF DEATH MONTH: February DAY: 1 YEAR: 87 — 2b. HOUR: 10:25AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: Dec. DAY: 19, YEAR: 1905	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 201 Russell Avenue 20760
14. FATHER'S NAME FIRST: James MIDDLE: L. LAST: Wesley			15. MOTHER'S MAIDEN NAME FIRST: Addie MIDDLE: H. LAST: Tubbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): None	16b. SOCIAL SECURITY NO.: 215.52.2472	17. INFORMANT: L. Madge Allison ADDRESS: 207 Oak Lane N.W. Sister Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 mos

DUE TO, OR AS A CONSEQUENCE OF (b) C.O.P.D.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Cellulitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10/15/86 to date, 19__, that (I) (we) last saw the deceased alive on 1/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thos G. Ward — 22e. ADDRESS: 6116 Rockwood, Bethesda, Md 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb 5,1987	23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery	23d. LOCATION CITY OR TOWN: Pikesville COUNTY: Balto STATE: Md.
24. FUNERAL DIRECTOR NAME: [signature] ADDRESS: Singleton Funeral Home, Glen Burnie, Md.		25a. DATE REC'D BY REGISTRAR: FEB 3 1987	25b. REGISTRAR'S SIGNATURE: [signature]

44718 FEB 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05369

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	LOUISE	DREWES	FEBRUARY 14, 1987	12:45 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
FEMALE	WHITE	JULY 24, 1915	71 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
ST. LOUIS, MO.	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	PRIVATE RESIDENCE	ART EDUCATOR	RETIRED

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	BETHESDA		5014 RIVER HILL ROAD 20816

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DR. BENNO	EDWARD	LISCHER	MARY	LOUISE	HUBER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	NONE	498-34-8374	WOLFRAM DREWES	5014 RIVER HILL RD. BETHESDA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma Liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE John A. Miller MD — DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED February 15, 1987

22d. PHYSICIAN'S NAME (Type) JOHN A. MILLER — 22e. ADDRESS 3301 WOODBURN ROAD, ANNANDALE, VA. 22003

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
CREMATION	2/15/87	METROPOLITAN CREMATORY	ALEXANDRIA, VIRGINIA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GREEN FUNERAL HOME	721 ELDEN ST. HERNDON, VA	FEB 19 1987	Julia Dickson Lindsay

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1

046084 MAR-5 '87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 70

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: GIUSEPPA RECUPERO DUNCANSON

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 13 1987

2b. HOUR: 9:40 P M

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 21 1960

6. AGE (IN YEARS LAST BIRTHDAY): 26 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ITALY

7b. CITIZEN OF WHAT COUNTRY?: ITALY

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: DISTRICT OF

13b. COUNTY: COLUMBIA

13c. CITY OR TOWN: WASHINGTON, D.C

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 14 NEEDLE GREEN, SW 20032

99999

14. FATHER'S NAME FIRST MIDDLE LAST: VINCINSO RECUPERO

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: FARO PAOLA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): NONE

16b. SOCIAL SECURITY NO.: 592-40-1663

17. INFORMANT ADDRESS: NIGEL N.DUNCANSON,14 NEEDLE GREEN, SW, WASHINGTON, DC 20032

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYELOGENOUS LEUKEMIA

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 30, 19 87, to FEBRUARY 13, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward P. Fox

DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]

22c. DATE SIGNED: 17 Feb. 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): E.P.FOX, LT, MC, USNR

22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY: CAPPELLA S CATER'NA

23d. LOCATION CITY OR TOWN COUNTY STATE: CATANIA, SICILY, ITALY

24. FUNERAL DIRECTOR NAME ADDRESS: CHAMBERS FUNERAL HOME SILVER SPRING, MARYLAND

25a. DATE REC'D. BY REGISTRAR: MAR 04 1987

25b. REGISTRAR'S SIGNATURE: [signature]

BP

99999

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows homicide, suicide, or other traumatic event, the medical examiner must be notified at once.

043094 FEB -5 87

EDR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 71
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE J. LAST DUNN, Sr.

2a. DATE OF DEATH: MONTH DAY YEAR 2-1-87

2b. HOUR 5:15 AM

3. SEX: male

4. RACE: white

5. DATE OF BIRTH: MONTH 07 DAY 20 YEAR 98

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carriage Hill Nsg Center

12a. USUAL OCCUPATION (FOR WHOM WORKED DURING LIFE): Chief Deputy Clerk of Court

12b. KIND OF BUSINESS OR INDUSTRY: Judicial

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 1103 Devere Dr. S.S. MD 20903

14. FATHER'S NAME: FIRST Michael MIDDLE LAST Dunn

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST not available

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW I

16b. SOCIAL SECURITY NO.: 180-10-2575

17. INFORMANT: William J. Dunn, Jr. ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE — 2 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b) URINARY INFECTION — 2 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONIA, MALNUTRITION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from _____, 19 83, to JAN 31, 19 87, that (I) (~~we~~) last saw the deceased alive on JANUARY 31, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Edward A. Beeman MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: FEB 1, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDWARD A. BEEMAN

22e. ADDRESS: 8830 CAMERON ST. SILVER SPRING MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 4 1987

23c. NAME OF CEMETERY OR CREMATORY: Saints Peter & Paul Cemetery

23d. LOCATION: CITY OR TOWN Broomall, COUNTY, STATE Pennsylvania

24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS 7557 Wisconsin Avenue Bethesda, MD 20814

25a. DATE REC'D. BY REGISTRAR: FEB 4 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

043709 FEB 11 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05372
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST BEILE MIDDLE B. LAST Eck

2a. DATE OF DEATH: MONTH 2 DAY 4 YEAR 87

2b. HOUR 7 45 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 01 DAY 14 YEAR 1885

6. AGE (IN YEARS LAST BIRTHDAY): 102 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Chevy Chase

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BETHESDA Retirement + Nsg. Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 7200 Nevis Road (20817)

14. FATHER'S NAME: FIRST Selig MIDDLE LAST Halsband

15. MOTHER'S MAIDEN NAME: FIRST Helen MIDDLE LAST Birkoff

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): -------

16b. SOCIAL SECURITY NO.: 579-44-2232

17. INFORMANT: Gerhard Eck; Son; ADDRESS 7200 Nevis Road; Bethesda, Md. 20817

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/10 19 87 to 2/4 19 87 that (I) (we) last saw the deceased alive on 1/10/87 19 and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.

22b. SIGNATURE: James Brodsky MD DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-4-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James Brodsky MD

22e. ADDRESS: 4701 Willard Ave Chevy Chase MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/8/87

23c. NAME OF CEMETERY OR CREMATORY: B'Nai Israel Cong. Cemetery; Oxon Hill; P.G.; Md.

23d. LOCATION: CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 9 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lordeen

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

043899 FEB 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

87 05373
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST HOWARD; MIDDLE J.; LAST EISEN

2a. DATE OF DEATH — KNOWN ☑ ESTIMATED ☐: MONTH 2, DAY 7, YEAR 1987

2b. HOUR 3:11 P.M.

3. SEX: Male

4. RACE: Cauc.

5. DATE OF BIRTH: MONTH 07, DAY 03, YEAR 42

6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS. — IF UNDER 1 YR.: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

2c. DATE PRONOUNCED DEAD: MONTH 2, DAY 7, YEAR 1987

2d. HOUR 3:11 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PHYSICIAN

12b. KIND OF BUSINESS OR INDUSTRY: MEDICINE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: BETHESDA

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 7206 HONEYWELL LANE 20814

14. FATHER'S NAME: FIRST Arnold; MIDDLE; LAST Eisen

15. MOTHER'S MAIDEN NAME: FIRST Ruth; MIDDLE; LAST Abramowitz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ------

16b. SOCIAL SECURITY NO.: 263-64-1379

17. INFORMANT: Laura P. Eisen; 7206 HoneywellLane Bethesda, Md. 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPMYXIA	ACUTE
DUE TO, OR AS A CONSEQUENCE OF (b)	HANGING	ACUTE
DUE TO, OR AS A CONSEQUENCE OF (c)	DEPRESSION	INDEF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR 1430 A.M. P.M., MONTH 2, DAY 7, YEAR 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): FOUND HANGING BY FAMILY

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME

21f. LOCATION — STREET: 7206 HONEYWELL LANE; CITY OR TOWN: BETHESDA; COUNTY: MONT; STATE: MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED 2-7-86

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C. MAYLE ADDRESS 8200 Wisconsin Ave Bethesda, Md 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-9-1987

23c. NAME OF CEMETERY OR CREMATORY: Judean Memorial Gardens

23d. LOCATION — CITY OR TOWN: Olney; COUNTY: Montgomery; STATE: Maryland

24. FUNERAL DIRECTOR — NAME: Danzansky-Goldberg Chapels; ADDRESS: 1170 Rockville Pike Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 11 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rawlins

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

044365 FEB 17 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 74
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elsie MIDDLE: M. LAST: Ely

2a. DATE OF DEATH MONTH 2 DAY 10 YEAR 87

2b. HOUR 12:10 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH June DAY 6, YEAR 1929

6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS) (IF UNDER 24 HRS.: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Frederick

13c. CITY OR TOWN: Frederick

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 5606 Steuer Pl. Lot 21 21701

14. FATHER'S NAME FIRST: Richard MIDDLE: LAST: Fee

15. MOTHER'S MAIDEN NAME FIRST: Rachel MIDDLE: LAST: Milwee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 229-32-6539

17. INFORMANT: Oscar Ely, ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease — 10 years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cor Pulmonale

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this physician) attended the deceased from Feb 10, 19 87, to 2/10, 19 87, that (I) (we) last saw the deceased alive on 2/9, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Carl L. Schoenberger

DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Carl L. Schoenberger

22e. ADDRESS: 16220 Frederick Rd Gaithersburg

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 14, 1987

23c. NAME OF CEMETERY OR CREMATORY: Fee Cemetery

23d. LOCATION CITY OR TOWN: Rose Hill, COUNTY: Lee, STATE: Virginia

24. FUNERAL DIRECTOR NAME: Olin L. Molesworth, P.A., ADDRESS: Damascus, Md.

25a. DATE REC'D BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045682 MAR - 2 '87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

87 05375
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) M. Eugene Evans
2a. DATE OF DEATH MONTH 2 DAY 25 YEAR 87
2b. HOUR 1900 PM
3. SEX Male
4. RACE White
5. DATE OF BIRTH MONTH Nov. DAY 21 YEAR 1901
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 2 HRS.: HOURS MIN.
7a. BIRTHPLACE California
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Takoma Park
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital
12a. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE) Tess. Home Study
12b. KIND OF BUSINESS OR INDUSTRY Retired

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12c. STATE Md. COUNTY Pikes.
12f. CITY OR TOWN Takoma Park
12d. INSIDE CITY LIMITS? YES [X] NO [ ]
12e. STREET ADDRESS / ZIP CODE 7008 Sycamore Ave. Tak. PK.

14. FATHER'S NAME FIRST William MIDDLE LAST Evans
15. MOTHER'S MAIDEN NAME FIRST Geanettia MIDDLE LAST Sinson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR AND DATES)
16b. SOCIAL SECURITY NO. 578-46-8133
17. INFORMANT Fern Evans ADDRESS 12e.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
DUE TO, OR AS A CONSEQUENCE OF (b) lymphoma - stage 4.
DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition - anorexia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/17 19 87, to 2/25 19 87, that (I) (~~we~~) last saw the deceased alive on 2/25 19 87, and that in (my) (~~our~~) opinion death occurred at the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE Amito S. Hon DEGREE
ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED 2/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH H O
22e. ADDRESS 7610 Carroll Ave Takoma PK, Md.

23a. BURIAL, CREMATION, REMOVAL Burial.
23b. DATE Mar, 2, 1987
23c. NAME OF CEMETERY OR CREMATORY George Washington, Riggs Rd. P. G. Co, Md
23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR (NAME) Takoma Funeral Home. ADDRESS 254 Carroll St. N. W. D.
25a. DATE REC'D. BY REGISTRAR FEB 27 1987
25b. REGISTRAR'S SIGNATURE Julia Davidson-Lawrence

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

45869 MAR 4 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 76
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Gerard MIDDLE M. LAST Feltgen		2a. DATE OF DEATH MONTH DAY YEAR February 24, 1987	2b. HOUR 1:07 pm
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 12, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Luxembourg	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS / ZIP CODE 6908 Fairfax Road Bethesda, Maryland 20814
14. FATHER'S NAME FIRST Nicola MIDDLE LAST Feltgen		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Soisson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 577-42-9555	17. INFORMANT ADDRESS Ketty Feltgen 6908 Fairfax Road Bethesda, Maryland 20814 (Wife)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b) Influenza-like Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Oct 86 to date 19 that (I) (we) last saw the deceased alive on 2/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 2/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD — 22e. ADDRESS 6116 Richmond, Bethesda 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE February 26, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN Silver Spring COUNTY STATE Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda, Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814		25a. DATE REC'D BY REGISTRAR MAR 02 1987	25b. REGISTRAR'S SIGNATURE Julia Dendor-Kendrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or here is shown any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

B

044146 FEB 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05371
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Rosalie Straub Fey		2a. DATE OF DEATH (MONTH DAY YEAR): February 10, 1987	2b. HOUR: 2:15p M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH (MONTH DAY YEAR): Aug. 31, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS / HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Claims	12b. KIND OF BUSINESS OR INDUSTRY: Insurance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 101 Odend-hal Avenue/20877
14. FATHER'S NAME FIRST / MIDDLE / LAST: Jacob Straub			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Emma Ueliggier	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-50-5697	17. INFORMANT: Joan F. Courtney	ADDRESS: 12301 Bradbury Drive Gaithersburg, MD 20878

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ischemic CARDIOMYOPATHY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 YRS
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from MAY 1986 to FEBRUARY 1987, that (I) (we) last saw the deceased alive on FEBRUARY 10 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S. Hellman	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen Hellman	22e. ADDRESS: 6246 MONTROSE Rd Rockville MD 20852	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 14, 1987	23c. NAME OF CEMETERY OR CREMATORY: Eastlawn Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bloomington, Illinois
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc.	ADDRESS: 300 West Montgomery Avenue Rockville, Maryland	25a. DATE REC'D. BY REGISTRAR: FEB 17 1987	25b. REGISTRAR'S SIGNATURE: Julia Kirkman Andrews

043330 FEB 087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05318

1. DECEASED NAME (TYPE OR PRINT): FIRST Nellie MIDDLE ~~F~~ L. LAST Fitzgerald

2a. DATE OF DEATH: MONTH FEB. DAY 3 YEAR 1987

2b. HOUR 430 P.M.

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH: MONTH 7 DAY 29 YEAR 06

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD.

10. CITY OR TOWN OF DEATH: Kensington

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Circle Manor Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2701 Ara Dr 20906

14. FATHER'S NAME: FIRST Charles MIDDLE Lytle LAST ~~Fitzgerald~~

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Jones LAST ~~Fitzgerald~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: 219-10-3180

17. INFORMANT: Bruce Fitzgerald

ADDRESS: 2701 Ara Dr. 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPTICEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ONE WEEK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 912

DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE CEREBRAL INFARCTION — 1 YEAR

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SENILE DEMENTIA; INANITION; RECURRENT ASPIRATION

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1986, to Feb. 3, 1987, that (I) (we) last saw the deceased alive on 1/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin Shargel — DEGREE: M.D. — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/3/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN C SHARGEL

22e. ADDRESS: 3720 FARRAGUT AVE. KENSINGTON, MD - 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/6/87

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem. (Hampden)

23d. LOCATION: CITY OR TOWN Balto. COUNTY STATE Maryland

24. FUNERAL DIRECTOR: NAME A. Alan Seitz, Jr. ADDRESS 3818 Roland Ave. 21211

25a. DATE REC'D. BY REGISTRAR: FEB 5 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

045708 MAR 3 0

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 053 79
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Margaret MIDDLE L. LAST Flanigan

2a. DATE OF DEATH: MONTH 2 DAY 27 YEAR 87

2b. HOUR 6:37 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH May DAY 25 YEAR 1896

6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. IF UNDER 1 YEAR: MONTHS / DAYS / HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Sandy Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Friends House Nursing

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laundry Business

12b. KIND OF BUSINESS OR INDUSTRY: Proprietor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: Sandy Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 17340 Quaker Lane 20860

14. FATHER'S NAME: FIRST James MIDDLE LAST Flanigan

15. MOTHER'S MAIDEN NAME: FIRST Margaret MIDDLE LAST O'Brien

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO: 213 09 9246A

17. INFORMANT'S NAME, ADDRESS: 2008 Windrush Lane Sandy Spring, Md. Virginia Hewitt (Niece)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk / Yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Organic Brain Syndrome

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/19, 1986 to 2/27, 1987, that (I) (we) last saw the deceased alive on 2/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. H. Lyons MD

22e. ADDRESS: 18011 Prince Phillip Dr. Olney Md 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3/3/87

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION: CITY OR TOWN S.S. COUNTY Mont. STATE Md.

24. FUNERAL DIRECTOR: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified of all

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of all

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

044024 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05380
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Shirley M. Forder		2a. DATE OF DEATH MONTH DAY YEAR: February 3, 1987	2b. HOUR: 1:25 P M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: November 19, 1931	6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 13115 Burlwood Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Silver Spring Rotary Club
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 13115 Burlwood Drive 20853
14. FATHER'S NAME FIRST / MIDDLE / LAST: Henry J. Meier		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Ethel Mae Magee	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 216-28-4370	17. INFORMANT: James E. Forder, Jr. Husband — ADDRESS: Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral metastasis	days
DUE TO, OR AS A CONSEQUENCE OF (b)	metastatic melanoma	months
DUE TO, OR AS A CONSEQUENCE OF (c)	primary melanoma	years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12-18, 19 29, to Feb 3, 19 87, that (I) (we) last saw the deceased alive on Feb 1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wilfred R. Ehrmanbrant — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]		22c. DATE SIGNED: 2/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wilfred R. Ehrmanbrant	22e. ADDRESS: 11120 Rockville Pike, Rockville Md 20852	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 6, 1987	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rockville Montgomery Md.
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 13 1987	25b. REGISTRAR'S SIGNATURE: Avis Dickerson-Lindsay

045326 FEB 26 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 81
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MASHA MIDDLE LAST FORMAN		2a. DATE OF DEATH MONTH DAY YEAR 2-14-87	2b. HOUR 3:06 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 10, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD.
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Rockville	YES XX NO ☐	6121 Montrose Road 20852

14. FATHER'S NAME FIRST Unknown MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 050-14-6921A	17. INFORMANT Harriet F. Laitman — ADDRESS 11913 Reynolds Avenue, Potomac, Maryland 20854

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTETION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I/(this hospital)) attended the deceased from 7-29, 19 86, to 2-14, 19 87, that (I/(we)) last saw the deceased alive on 2-14, 19 87, and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did)/did not) view the body after death.

22b. SIGNATURE Loreto S. Albiol, MD — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑		22c. DATE SIGNED 2-14-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO S. ALBIOL	22e. ADDRESS 6121 MONTROSE Rd.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/15/1987	23c. NAME OF CEMETERY OR CREMATORY Judena Mem. Gardens	23d. LOCATION TOWN Olney, COUNTY Montgomery, Md. STATE
24a. FUNERAL DIRECTOR NAME EDWARD M. STEIN ADDRESS HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR FEB 19 1987	25b. REGISTRAR'S SIGNATURE Jackie Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

044144 FEB 17 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05382

1. DECEASED NAME (TYPE OR PRINT) FIRST John MIDDLE Gordon LAST Foster, Sr.		2a. DATE OF DEATH MONTH DAY YEAR 2/10/87	2b. HOUR 0004 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 23, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove SGAH Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Co. American Oil

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Gaithersburg	YES [X] NO [ ]	10320 Redgeline Drive / 20879

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
J.	Frank	Foster	Lulu		Trimble

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW II	218-09-0523	Rita Foster,	Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	15 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Arteriosclerosis	Unknown
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes Mellitus, COPD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 12, 1983, to Feb 10, 1987, that (I) (we) last saw the deceased alive on Oct 29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2-11-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James R. Moore Jr. MD	207 Brookes Ave Gaithersburg Md 20877

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-13-87	Quantico National Cemetery	Triangle, Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Richard Rapp, Inc.	1804 T Street, NW, Washington, DC 20009	FEB 17 1987	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

045680 MAR 2 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 053 85

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Edna — MIDDLE: — LAST: Freedman

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH DAY YEAR: 2/24 1987

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: Apr. 28, 1901

6. AGE (IN YEARS) LAST BIRTHDAY: 85 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: 2/24 1987

2d. HOUR: 11:30 A. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10000 Brunswick Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: -------

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 10000 Brunswick Avenue 20910

14. FATHER'S NAME — FIRST: Morris — MIDDLE: — LAST: Glick

15. MOTHER'S MAIDEN NAME — FIRST: Anna — MIDDLE: — LAST: Glick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ---------

16b. SOCIAL SECURITY NO.: 215-03-4672

17. INFORMANT (NAME, ADDRESS): Rockville, Md., 20853 Arthur J. Freedman; 4528 Hornbean Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2/24/87

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-26-1987

23c. NAME OF CEMETERY OR CREMATORY: Hebrew Young Mens Cem.

23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Baltimore, Maryland

24. FUNERAL DIRECTOR — NAME: Danzansky-Goldberg Chapels; ADDRESS: 1170 Rockville Pike Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 27 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

44444 FEB 19 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05384
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: Bernardine	LAST: Freitag	2a. DATE OF DEATH MONTH 02 DAY 01 YEAR 87
2b. HOUR 12:15 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH Nov. DAY 21 YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7760 Heatherton La.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD	13b. COUNTY: Mont.	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 7760 Heatherton La.

14. FATHER'S NAME FIRST: Earle	MIDDLE: Sylvester	LAST: Carlin	15. MOTHER'S MAIDEN NAME FIRST: Eva	MIDDLE: Marie	LAST: Austin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 577-90-5358	17. INFORMANT ADDRESS: Janet Freitag 8908 Battery Pl. Beth., MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	15 min.
DUE TO, OR AS A CONSEQUENCE OF (b)	obstructive Lung Disease	11 yr.
DUE TO, OR AS A CONSEQUENCE OF (c)	Brain hemorrhage	11 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from June 21, 19 86, to Feb 01, 19 87, that (I) (we) last saw the deceased alive on Jan 28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frank J. Mayo, MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-3-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frank J. MAYO, MD	22e. ADDRESS: 16220 Frederick Rd #213 Gaithersburg, MD 20877	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/4/87	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN: Silver Spring, MD COUNTY / STATE
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016		25. DATE RECEIVED BY REGISTRAR: FEB 13 1987	26. REGISTRAR'S SIGNATURE: Julia Dickson Rodney

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked on Item 7b, notify city injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

044163 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 83
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: SARAH MIDDLE: C. LAST: FRIEDBERG
2a. DATE OF DEATH — MONTH 2 DAY 9 YEAR 87
2b. HOUR 935 PM
3. SEX: F
4. RACE: W
5. DATE OF BIRTH — MONTH 12 DAY 27 YEAR 1893
6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA, MD
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: ROCKVILLE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): — Housewife
12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: ROCKVILLE
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 6125 MONTROSE RD 20852

14. FATHER'S NAME — FIRST: HYMAN MIDDLE: LAST: COHEN
15. MOTHER'S MAIDEN NAME — FIRST: ANNIE MIDDLE: LAST: GOODMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): UNKNOWN (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 578 16 9267
17. INFORMANT: CHART Morris A. Friedberg ADDRESS 10920 Conn Ave Kensington, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CEREBROVASCULAR DISEASE

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/16, 19 86, to 2/9, 19 87, that (I) last saw the deceased alive on 2/9, 19 87, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.
22b. SIGNATURE: Alan S Chanales — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED 2/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN S. CHANALES
22e. ADDRESS: 15225 SHADY GROVE RD ROCKVILLE MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb 12 1987
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION — CITY OR TOWN: Arlington, COUNTY / STATE: VA
24. FUNERAL DIRECTOR — NAME: Ives-Pearson ADDRESS: Arlington, VA
25a. DATE REC'D BY REGISTRAR: FEB 13 1987
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "Yes" in any instance, the traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045872 MAR

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 5 3 8 0

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Orlo — MIDDLE: H. — LAST: Frost

2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ — MONTH DAY YEAR: Feb 24 1987 — 2b. HOUR: 9:00 A.M.

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH (MONTH DAY YEAR): Sept. 30 1907 — 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN

2c. DATE PRONOUNCED DEAD: Feb 24 1987 — 2d. HOUR: 9:00 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass. — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Sol. Spg. — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 314 Whitestone Rd — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman — 12b. KIND OF BUSINESS OR INDUSTRY: Home Improvement

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Sil. Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 314 Whitestone Road 20901

14. FATHER'S NAME — FIRST: unknown — MIDDLE — LAST: Frost

15. MOTHER'S MAIDEN NAME — FIRST: unknown — MIDDLE — LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-01-6674

17. INFORMANT — ADDRESS: Vera E. Frost wife same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep MEDICAL EXAMINER — DATE SIGNED: Feb 24 1987

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. — ADDRESS: 1919 Seminary Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burail — 23b. DATE: Feb. 26, 1987 — 23c. NAME OF CEMETERY OR CREMATORY: Norbeck Memorial Park — 23d. LOCATION CITY OR TOWN: Olney — COUNTY: Montgomery — STATE: Maryland

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. — ADDRESS: 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Deaton Rudasa

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

1

4-4580 FEB 19 87

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 81
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELIZABETH MIDDLE: L LAST: GARANYI

2a. DATE OF DEATH MONTH DAY YEAR: 2-10-87

2b. HOUR: 12:19 PM

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: JULY 3 1908

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): HUNGARY

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY: HOMEMAKER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 228 University Blvd. E. 20901

14. FATHER'S NAME FIRST: Paul MIDDLE: LAST: Laczko

15. MOTHER'S MAIDEN NAME FIRST: Maria MIDDLE: LAST: Kando

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-42-4622

17. INFORMANT: daughter Agnes Miles ADDRESS: 9909 Blundon Dr. #102 Silver Spring, Md. 20902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) HEPATO-RENAL SYNDROME

DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-29- 19 87 to 2-10- 19 87 that (I) (we) last saw the deceased alive on Feb. 10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Tony P. Kannarkat MD

DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TONY P. KANNARKAT.

22e. ADDRESS: 8201 16th St SILVER SPRING, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 12, 1987

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Silver Spring Montgomery Md.

24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE: Julia Bowden-Rendrec

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

043861

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05388
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Elbert MIDDLE R. LAST Gardner		2a. DATE OF DEATH MONTH DAY YEAR Feb. 7, 1987	2b. HOUR 8:18 a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grosvenor Health Care	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Carpenter

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE 12324 Middle Road 20906

14. FATHER'S NAME FIRST Unknown MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-12-7255	17. INFORMANT Shirley M. Bruce (daughter)	ADDRESS same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorresp arrest — 6 min

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma prostate — 6 yr

DUE TO, OR AS A CONSEQUENCE OF (c) metastasis to brain — 4 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 4/4/85 CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/4/85, 19 85, to 2/7, 19 87, that (I) (we) last saw the deceased alive on 2/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Lewis N Cahill MD	DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/7/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS N CAHILL MD	22e. ADDRESS 5411 W. CEDAR LN BETHESDA MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/11/87	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	23d. LOCATION CITY OR TOWN Rockville COUNTY STATE Maryland
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike, Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR FEB 11 1987	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The [illegible] that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified of one.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

043710 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 05389
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: PEARL MIDDLE: LAST: GARTNER

2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1987

2b. HOUR: 3:35pM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Sept. 4, 1906

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Chevy Chase Retirement & Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY: ----------

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS / ZIP CODE: 4201 Cathedral Ave.,N.W. (20016)

14. FATHER'S NAME FIRST MIDDLE LAST: (Unknown)

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Sarah (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): ---------

16b. SOCIAL SECURITY NO.: 321-09- 1440

17. INFORMANT ADDRESS: Susan Goldstein;Granddaughter;8710 Hartsdale Avenue;Bethesda,Md.20834

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal metastatic carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF (b) —
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES ☐ NO X

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): —

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: —

22a. I certify that (I) (this hospital) attended the deceased from January, 1987, to February, 1987, that (I) (we) last saw the deceased alive on 2/4/87, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): OSOTH ~~ANONG~~ LEKAGUL, M.D.

22e. ADDRESS: 7425 Arlington Road; Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/6/87

23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Adelphi; P.G.; Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 9 1987

25b. REGISTRAR'S SIGNATURE: Julia Dawson Rudasa

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

999999

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

045264 FEB 26 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 90
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Naomi / / Gershowitz		2a. DATE OF DEATH MONTH DAY YEAR: 2-19-87	2b. HOUR: 7:59 P.M.
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 3-28-19	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	15311 Pine Orchard Drive, #2G (20906)

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Max / / Exler	Mollie / / Krucoff

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT NAME, ADDRESS
NO	--------	215-48-3352	Albert Gershowitz; Husband; 15311 Pine Orchard Drive; Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiorespiratory arrest — 1 min

DUE TO, OR AS A CONSEQUENCE OF (b) disseminated cancer of breast — 7 mo.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/19, 19 87 to 2/19, 19 87, that (I) (we) last saw the deceased alive on 2/19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Bruce A. Silver	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
BRUCE A. SILVER	106 Irving St., N.W., Washington, DC 20010

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/22/87	Mt. Lebanon Cemetery	Adelphi; P.G.; Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 24 1987	

DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

044369 FEB 17 87

FOR STATE REGISTRAR

Film G626 Item #13a 13b, c & e. 4/13/87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05391

1. DECEASED NAME (TYPE OR PRINT) FIRST: Loretta MIDDLE: R. LAST: Giasson

2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR: Feb 10 1987 — 2b. HOUR: 120 AM/PM

3. SEX: F

4. RACE: W

5. DATE OF BIRTH MONTH DAY YEAR: Dec 12 35

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS. — IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: Feb 10 1987 — 2d. HOUR: 130 AM/PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass.

7b. CITIZEN OF WHAT COUNTRY? USA.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross-Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Mass. Maryland

13b. COUNTY: Bristol Montgomery

13c. CITY OR TOWN: New Bedford Chevy

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 506 Ashley Blvd. 02745 3722 Manor

14. FATHER'S NAME FIRST: Adolphe MIDDLE: Chase LAST: Richer

15. MOTHER'S MAIDEN NAME FIRST: Roseanna MIDDLE: Apt. 3 #20815 LAST: Phaneuf

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 013 16 8418

17. INFORMANT: Richard R. Giasson(son) ADDRESS: 204 E. Joppa Road Baltimore, MD21204

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Inf

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Feb 10, 1987

EXAMINER'S NAME (TYPE OR PRINT) ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 13 1987

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery #2

23d. LOCATION CITY OR TOWN: New Bedford, COUNTY STATE: Mass.

24. FUNERAL DIRECTOR NAME ADDRESS: Ives-Pearson F.H. Arlington, Va 22201

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

99999

87 86 25M BP

DHMH - 17 (VR A15 ME (5))

045885 MAR 4 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05392

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bertie MIDDLE: E. LAST: Giessman

2a. DATE OF DEATH MONTH DAY YEAR: 2 11 87

2b. HOUR: 0451 A.M.

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH MONTH DAY YEAR: 4 6 98

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: at home.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Alleghany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 608 E.1st St. 21502

14. FATHER'S NAME FIRST: John MIDDLE: G. D. LAST: Spiker

15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: C. LAST: Tucker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-70-1333

17. INFORMANT: Rev.Dr.Richard Reichard ADDRESS: 9701 Veirs Dr Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 1 19 86 to Feb 11 19 87 that (I) (we) last saw the deceased alive on Feb 10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (not (did) (did not) view the body after death.

22b. SIGNATURE: Thomas E. Dodey, MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb 11, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas E. Dodley, MD

22e. ADDRESS: 17904 Georgia Avenue Olney, Maryland 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb.16,1987

23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Oakland, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: The Hysong Co. 1300 N St.N.W.Wash.D.C.

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] the other copies on bonapapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83 (VRA 1S, 4)

044028 FEB 17

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 93
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. Pages 1 and 2 should be notified at once the medical examiner, if the medical examiner has been notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Gertrude Middle C. Last Gill
2a. DATE OF DEATH: Month February Day 6 Year 1987
2b. HOUR: 10:00 AM
3. SEX: female
4. RACE: Caucasian
5. DATE OF BIRTH: Month October Day 30 Year 1917
6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10622 S. Dunmoor Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bank Teller
12b. KIND OF BUSINESS OR INDUSTRY: National Savings & Trust

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 10622 S. Dunmoor Drive 20901

14. FATHER'S NAME: First Herbert Middle Lee Last Gill
15. MOTHER'S MAIDEN NAME: First Catherine Middle C. Last Mackessy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-05-7491
17. INFORMANT: Sister Kathleen Cox
ADDRESS: Box 2021 Pike Station Rockville, Md. 20852

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the thyroid — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Local metastases — 1 yr.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Sept 5, 1958, to February 6, 1987, that (I) (we) lost sight of the deceased alive on Feb 6, 1987, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.
22b. SIGNATURE: Raymond Bradshaw, Jr MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Raymond Bradshaw, Jr. MD
22e. ADDRESS: 345 University Blvd. W. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 9, 1987
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION: CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md.
24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md.
25a. DATE REC'D BY REGISTRAR: FEB 13 1987
25b. REGISTRAR'S SIGNATURE

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

045020 FEB 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05394
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: LESLIE GILLIS, JR		2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 12 1987	2b. HOUR: 5:40 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 18 1907	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MISSISSIPPI	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County MD.
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Developer	12b. KIND OF BUSINESS OR INDUSTRY: Real Estate
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: ROCKVILLE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ / 13e. STREET ADDRESS / ZIP CODE: 1001 WADE AVENUE 20851
14. FATHER'S NAME FIRST MIDDLE LAST: LESLIE GILLIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Lillie Netterville	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): 1929-1959	16b. SOCIAL SECURITY NO.: 577-42-1193	17. INFORMANT (Executor) ADDRESS: Suite 500/20005 A. Kolbet Schrichte 1133 FifteenthSt.N.W.,D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PANCREATIC CANCER

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 17, 19 87, to FEBRUARY 12, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Pierdinock	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 17 Feb 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. PIERDINOCK, LCDR, MC, USNR		22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 18, 1987	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland Prince Georges Md.
24. FUNERAL DIRECTOR NAME ADDRESS: Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland		25a. DATE REC'D BY REGISTRAR: FEB 20 1987	25b. REGISTRAR'S SIGNATURE: [signature]

045180 FEB 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 05395

1. DECEASED NAME (TYPE OR PRINT): FIRST Harry MIDDLE William LAST Frederick Glemser
2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH Feb. DAY 20 YEAR 1987
2b. HOUR 5P M
3. SEX: Male
4. RACE: Cauc.
5. DATE OF BIRTH MONTH Dec. DAY 12 YEAR 1905
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN
2c. DATE PRONOUNCED DEAD MONTH Feb. DAY 20 YEAR 1987
2d. HOUR 6:08p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey
7b. CITIZEN OF WHAT COUNTRY? United States
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Chevy Chase
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3406 Inverness Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Patent Attorney
12b. KIND OF BUSINESS OR INDUSTRY: Law

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: CHEVY CHASE
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS: 3406 INVERNESS DR 20815

14. FATHER'S NAME FIRST Frederick MIDDLE LAST Glemser
15. MOTHER'S MAIDEN NAME FIRST Caroline MIDDLE LAST Katza
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 577-12-8609
17. INFORMANT: Helen C. Glemser ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INDEF
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): —

19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —
20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. 1700 MONTH 2 DAY 20 YEAR 1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): COLLAPSED CUTTING WOOD
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME
21f. LOCATION STREET 3406 INVERNESS DR CITY OR TOWN Chevy Chase COUNTY Mont STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. [signature] TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED 2-20-87
EXAMINER'S NAME (TYPE OR PRINT): Francis C. Mayle, M.D. ADDRESS: 8200 Wisconsin Avenue Bethesda, Maryland 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 24, 1987
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park
23d. LOCATION CITY OR TOWN: Rockville COUNTY: STATE: Maryland
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS: 7557 Wisconsin Ave. Bethesda, Maryland 20814
25a. DATE RECEIVED BY REGISTRAR: FEB 24 1987
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

045880 MAR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05390
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: FRANCISCO JUAN GONZALEZ		2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 23 1987	2b. HOUR: 2:34 A M
3. SEX: MALE	4. RACE: HISPANIC	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 3 1921	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS, HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CUBA	7b. CITIZEN OF WHAT COUNTRY?: CUBA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: VA	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: BOX 38 c/o FBPO NORFOLK VA 99999

14. FATHER'S NAME FIRST MIDDLE LAST: SANTIAGO GONZALEZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: CLOTILDE SANCHEZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 267-11-9008	17. INFORMANT ADDRESS: HAYDEE GONZALEZ, BOX 38,c/o FBPO NORFOLK,VA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) 23593

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ABDOMINAL AND RESPIRATORY SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(b) HEPATORENAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c) LYMPHOMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 23 19 86 to FEBRUARY 23 19 87 that (I) (we) last saw the deceased alive on FEBRUARY 23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: G. M. Perez, MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]		22c. DATE SIGNED: 24 Feb 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. M. PEREZ, LCDR, MC, USN	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 28 Feb 87	23c. NAME OF CEMETERY OR CREMATORY: U. S. Naval Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE: Guantanamo Bay, Cuba
24. FUNERAL DIRECTOR NAME ADDRESS: Capitol Funeral Service, Falls Church, VA		25a. DATE REC'D. BY REGISTRAR: MAR 02 1987	25b. REGISTRAR'S SIGNATURE: [signature]

999999

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requ[illegible] that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been s[illegible] by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then [illegible] the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bu[illegible] cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

045630 MAR-2 '87

17 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 05391
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Clara MIDDLE: RIVKA LAST: Gordon

2a. DATE OF DEATH MONTH 2 DAY 23 YEAR 87

2b. HOUR 6:45 A.M.

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH (MONTH DAY YEAR): SEPTEMBER 13, 1932

6. AGE (IN YEARS LAST BIRTHDAY): 54 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): EGYPT

7b. CITIZEN OF WHAT COUNTRY?: U S A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL

12a. USUAL OCCUPATION (TYPE OR PRINT, GIVE KIND OF WORK DURING MOST OF WORKING LIFE): RESEARCH ANALYST

12b. KIND OF BUSINESS OR INDUSTRY: ADDISON ELECTRI INSTITUTE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTOMGERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 806 ORANGE DRIVE 20901

14. FATHER'S NAME: AZRIEL MIDDLE: EISEN

15. MOTHER'S MAIDEN NAME: SEMIA MIDDLE: GREENBERG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216-40-5685

17. INFORMANT: RACHEL SIMON, ADDRESS: 10903 LOMBARDY ROAD SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3hrs

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Disease to Brain — 6 mos

DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma (Adenocarcinoma) — 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION: 2/21/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pathologic fracture (L) femur

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/20, 1987, to 2/23, 1987, that (I) (~~was~~) last saw the deceased alive on 2/22, 1987, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Alfred Munzer — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/23/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Alfred Munzer, M.D.

22e. ADDRESS: 7600 Carroll Avenue Takoma Park, Md.

23a. BURIAL, CREMATION, REMOVAL: BURIAL

23b. DATE: 2/24/1987

23c. NAME OF CEMETERY OR CREMATORY: MOUNT LEBANON CEMETERY

23d. LOCATION (CITY OR TOWN, COUNTY, STATE): ADELPHI, PRINCE GEORGE'S COUNTY MARYLAND

24. NAME AND ADDRESS OF FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE: Julia Dickson Rudasill

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

044283 FEB 11

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05398
REG. NO.

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: PEARL — MIDDLE: W. — LAST: GORENSTEIN

2a. DATE OF DEATH — MONTH: FEBRUARY — DAY: 4, — YEAR: 1987

2b. HOUR: 9:45P M

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH: NOVEMBER — DAY: 17, — YEAR: 1895

6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): ALTHEA WOODLAND NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE): CLERK

12b. KIND OF BUSINESS OR INDUSTRY: SOCIAL SECURIT GOVERNMENT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 1000 DALEVIEW DRIVE 20901

14. FATHER'S NAME — FIRST: SAMUEL — MIDDLE: — LAST: WEISBERG

15. MOTHER'S MAIDEN NAME — FIRST: SARAH — MIDDLE: — LAST: HERZBERG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 577-20-9013

17. INFORMANT: EMANUEL FISHKIN, ADDRESS: 6101 16th STREET, N. W. WASHINGTON, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 27, 19 76, to Feb 4, 19 87, that (I) (we) last saw the deceased alive on Feb 4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bernard A. Fitzgerald MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-5-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. BERNARD A. FITZGERALD, M. D.

22e. ADDRESS: 217 UNIVERSITY BOULEVARD, EAST SILVER SPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL: BURIAL

23b. DATE: 2/6/1987

23c. NAME OF CEMETERY OR CREMATORY: JUDEAN MEMORIAL GARDENS

23d. LOCATION (CITY OR TOWN, COUNTY, STATE): OLNEY, MONTGOMERY, MARYLAND

24. FUNERAL DIRECTOR (NAME AND ADDRESS): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D BY REGISTRAR: FEB 09 1987

25b. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

045894 MR 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05399
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY MIDDLE: F LAST: GRAY
2a. DATE OF DEATH MONTH DAY YEAR: FEB 23 87
2b. HOUR: 3:15 PM
3. SEX: FEMALE
4. RACE: CAU
5. DATE OF BIRTH MONTH DAY YEAR: 11 22 89
6. AGE (IN YEARS LAST BIRTHDAY): ~~87~~ 98 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MISSOURI
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONT. CO MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FAIRLAND NURSING HOME
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LAWYER & SCHOOL TEACHER
12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: MONT
13c. CITY OR TOWN: SILVER SPRING
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 8505 SPRINGVALE ROAD 20910
14. FATHER'S NAME FIRST: CHARLES MIDDLE: W. LAST: GRAY
15. MOTHER'S MAIDEN NAME FIRST: LOUELLA MIDDLE: LAST: WISELY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 489-24-3199
17. INFORMANT: MARTHA CLAIBORN ADDRESS: 1908 DANA DR. ADELPHI, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORUL MONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS, TEMPORAL ARTERITIS

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 3 3, 1986 to present, 19____, that (I) (we) last saw the deceased alive on 2/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/23/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LUIS A. CASAS
22e. ADDRESS: 8317 CHERRY LA. LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: FEB. 28. 1987
23c. NAME OF CEMETERY OR CREMATORY: Walnut Ridge Cemetery
23d. LOCATION CITY OR TOWN: Fayette COUNTY: STATE: Missouri
24. FUNERAL DIRECTOR NAME: Takima Funeral Home ADDRESS: J. Chatten 25 Carroll St NW D.C.
25a. DATE REC'D BY REGISTRAR: MAR 02 1987
25b. REGISTRAR'S SIGNATURE: Julia Dawson-Rudacille

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or there is any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05400
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mildred MIDDLE: C. LAST: Gray		2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1987	2b. HOUR: 7 30 A.M.
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: June 3, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dietician	12b. KIND OF BUSINESS OR INDUSTRY: County Schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Bethesda	YES ☐ NO ☒	5521 McKinley Street/20817

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: William MIDDLE: LAST: Holt	FIRST: Emilie MIDDLE: LAST: Vogt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-32-2469	Barbara V. Baglin,	same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of the Bladder

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 2, 1987 to Feb 19, 1987 that (I) (~~we~~) last saw the deceased alive on Feb. 12 1987, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~do~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert D. Tauber M	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 19, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John F. Tauber, M.D.	8218 Wisconsin Avenue Bethesda, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	Feb. 19, 1987	Metropolitan Crem.	Alexandria, Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.	7557 Wisconsin Ave. Bethesda, MD 20814	FEB 24 1987	

1

043240 FEB - 6 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05401
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: A. LAST: Gregg		2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1987	2b. HOUR: 11:55AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 19, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: own home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 3497 S. Leisure World Blvd 20906
14. FATHER'S NAME FIRST: Jacob MIDDLE: LAST: Patterson		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: LAST: Wharton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 160 50 3098	17. INFORMANT: (daughter) Madelaine Smothers- — ADDRESS: 8500 Pelham Road Beth., Md. 20817

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) pulmonary abscess (pyogenic) — 2-3 wks

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): pulm emboli

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): —	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): —	21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-28- 19 86 to 2-2- 19 87 that (I) (we) last saw the deceased alive on 2/1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Catherine M. Chura, M.D. — DEGREE: ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Catherine Chura, M. D.	22e. ADDRESS: 18111 Prince Philip Dr. Olney, Maryland 20832	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-5-1987	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN: Silver Spring COUNTY: Montgomery STATE: Md.
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi Funeral Home — ADDRESS: 11800 N.H. Ave., Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR: FEB 5 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Fordham

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

044637 FEB 19 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 002
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Helen; MIDDLE: nmn; LAST: Grlicky

2a. DATE OF DEATH — MONTH DAY YEAR: February 15,1987

2b. HOUR: 6-00 A M

3. SEX: Female

4. RACE: Cauc.

5. DATE OF BIRTH — MONTH DAY YEAR: April 25, 1912

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10,000 Stedwick Rd. #204 20879

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 10,000 Stedwick Rd. #204,20879

14. FATHER'S NAME — FIRST: John; MIDDLE: —; LAST: Nyiri

15. MOTHER'S MAIDEN NAME — FIRST: Sarah; MIDDLE: —; LAST: Eles

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 283-10-8898

17. INFORMANT — ADDRESS: John Grlicky same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE — YEARS

DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): N/A

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/9, 19 86, to present, 19 ____, that (I) (we) last saw the deceased alive on 1/20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P. Petrick MD — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/16/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PATRICIA A. PETRICK, MD.

22e. ADDRESS: 14809 PHYSICIANS LANE #111, ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb.16,1987

23c. NAME OF CEMETERY OR CREMATORY: Balto./Wash. Crematory

23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Laurel, P.G., Maryland

24. FUNERAL DIRECTOR — NAME, ADDRESS: Muriel H. Barber Laytonsville, Md. 20879

25a. DATE REC'D BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The [illegible] of the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicia[illegible]

TO FUNERAL DIRECTOR: After this certificate has [illegible] by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 4/82 (VRA 15, 4)

46071 MAR -5 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 403
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Nettie MIDDLE H. LAST Gross
NETTIE H. GROSS

2a. DATE OF DEATH: MONTH 2 DAY 27 YEAR 87
2b. HOUR 1:45 A.M.

3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 5 DAY 3 YEAR 93
6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1948 Seminary Road
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Hairdresser
12b. KIND OF BUSINESS OR INDUSTRY: Beauty Salon

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 1948 Seminary Rd./20910

14. FATHER'S NAME: FIRST Richard MIDDLE -- LAST Gross
15. MOTHER'S MAIDEN NAME: FIRST Henrietta MIDDLE -- LAST Goette

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ---
16b. SOCIAL SECURITY NO.: 578-36-7265
17. INFORMANT: Herbert Lockett, ADDRESS: 110 Windsor Dr, Hagerstown, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease — 10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-28 19 86 to 2-27 19 87, that (I) [redacted] last saw the deceased alive on 12-28 19 86, and that in (my) [redacted] opinion death occurred on the date and hour and from the causes stated above. (I) [redacted] (did) ([redacted]) view the body after death.

22b. SIGNATURE: D. Sengstack, MD. DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-27-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): George F. Sengstack
22e. ADDRESS: 9241 Col. Blvd., Silver Spring, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 3/2/87
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Mem. Park
23d. LOCATION: CITY OR TOWN Rockville, MD, COUNTY, STATE

24. FUNERAL DIRECTOR: NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016
25a. DATE REC'D. BY REGISTRAR: MAR 04 1987
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within [illegible] by the attending physician and completed, filed in by the funeral director, page 3 retained by the hospital or attending physician. Page 4 may be [illegible] death.

TO FUNERAL DIRECTOR. After this certificate [illegible] should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene within 72 hours after death with the State Dept. of Health and Mental Hygiene [illegible], cremation, or removal.

IMPORTANT: If item 21 is marked or item [illegible] injury, [illegible] other traumatic event, the medical examiner must be notified at once.

Deceased with coroner cleared 2-27-87 2:30 PM (Dr John Rogers)

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

044452 FEB 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 054 04
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ethel MIDDLE: J. LAST: Grossman		2a. DATE OF DEATH MONTH DAY YEAR: Jan. 31, 1987	2b. HOUR: 11:15 p.m.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 13, 1894	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): AL	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carriage Mill-Silver Spring	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Mont.	Silver Spg.	YES ☒ NO ☐	9101 - 2nd Ave. 20910

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Jacob Seligman	Rachel Reiskin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		407-07-6674	Bernice R. Stern	4450 S. Park Ave. Chevy Chase, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca bladder — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): generalized arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-28, 1984, to 1-31, 1987, that (I) last saw the deceased alive on 1-28, 1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
D. Sengstack MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2-3-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
G. F. Sengstack, M.D.	3929 Ferrara Dr., Wheaton, Md. 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/4/87	King David Cem.	Falls Church, VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc.	5130 WI Ave. NW Wash., DC 20016	FEB 13 1987	Julia Davidson-Rudacs

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

x

045238 FEB 26

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 054 05

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mary — MIDDLE: — LAST: Hadgis

2a. DATE OF DEATH — MONTH DAY YEAR: February 17, 1987

2b. HOUR: 9:15p M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: July 16 1900

6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Asia Minor

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 259 Congressional Lane Apt.#402

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 259 Congressional Lane/20852 Apt. #402

14. FATHER'S NAME — FIRST: Neamthe — MIDDLE: — LAST: Samantzoglou

15. MOTHER'S MAIDEN NAME — FIRST: Paraskeui — MIDDLE: — LAST: Papakiroglou

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 164-50-0527

17. INFORMANT: Helen Pappas — ADDRESS: 11506 Stonewood Lane Rockville, Maryland 20852

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Respiratory Arrest	20 Min.
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis	3 Mon.
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Arteriosclerotic Disease	10 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ascities & CVA Severe Degenerative Atherosclerosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from April 19 84, to Feb. 17 19 87, that (I) (we) last saw the deceased alive on Feb. 13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: February 18, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen N. Jones, M.D.

22e. ADDRESS: 809 Viers Mill Road Rockville, Maryland 20851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb.21,1987

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION — CITY OR TOWN: Silver Spring — COUNTY — STATE: Maryland

24. FUNERAL DIRECTOR — NAME: Robert A. Pumphrey Funeral Home, INC. — ADDRESS: 7557 Wisconsin Ave Bethesda/Chevy Chase, Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Gordon-Lindsay

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

45437 FEB 27 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 400
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: GRACE MIDDLE: M. LAST: HAGENBAUGH

2a. DATE OF DEATH MONTH DAY YEAR: 2-24-87

2b. HOUR: 6P. M

3. SEX: FEMALE

4. RACE: white

5. DATE OF BIRTH MONTH DAY YEAR: 8 21 '95

6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silverspring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holycross Hospital S.S.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: M.D

13c. CITY OR TOWN: Silverspring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 901 Arcola ave MD 20902

14. FATHER'S NAME FIRST: (unknown) MIDDLE: LAST: Laub

15. MOTHER'S MAIDEN NAME FIRST: (unobtainable) MIDDLE: LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 189032119

17. INFORMANT (son) William J. Hagenbaugh, Jr. ADDRESS 137 Manhattan St., 18706 Ashley, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETIS
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~this hospital~~ attended the deceased from 19 85 to 24 FEB 19 87 that (I) ~~we~~ last saw the deceased alive on 24 FEB 19 87 and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~we~~ (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 25 FEB 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOCH MD

22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-28-1987

23c. NAME OF CEMETERY OR CREMATORY: Mapel Hill Cemetery

23d. LOCATION CITY OR TOWN: Hanover COUNTY: Township STATE: PA.

24. FUNERAL DIRECTOR NAME: Hines/Rinaldi Funeral Home ADDRESS: 11800 N.H. Ave. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

046661 MAR 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 401
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE ~~Margaret~~ C. LAST HAGGETT	2a. DATE OF DEATH MONTH 02 DAY 28 YEAR 87
2b. HOUR 8:35 A.M.	
3. SEX Female	4. RACE White
5. DATE OF BIRTH MONTH September DAY 22, YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
13a. STATE Maryland	13b. COUNTY Montgomery
13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE 1135 University Blvd., West 20902	
14. FATHER'S NAME FIRST Cleaves MIDDLE LAST Cole	15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE LAST Thurston
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 024-01-5266	17. INFORMANT John R. Jehle, ADDRESS Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	carcinomatosis	one month
DUE TO, OR AS A CONSEQUENCE OF (b)	adenocarcinoma of stomach	unknown
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from January 12, 19 87, to February 28, 19 87, that (I) (we) last saw the deceased alive on Fabruary 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Peter Pushkas	22e. ADDRESS 11510 Old Georgetown Rd. Rockville Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 3-5-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN Alexandria, COUNTY / STATE Virginia
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS 1804 T Street, nW, Washington, DC 20009		25a. DATE REC'D BY REGISTRAR MAR 09 1987	25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, further traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05 008

044186 FEB 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: JAMES D. HARDESTY

2a. DATE OF DEATH MONTH DAY YEAR: 2 7 87

2b. HOUR: 7:25 PM

3. SEX: M Male

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: Jan. 28, 1912

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Glazier

12b. KIND OF BUSINESS OR INDUSTRY: Walsh & Koehler

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Charles

13c. CITY OR TOWN: Waldorf

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS / ZIP CODE: 2317 Pinefield Rd 20601

14. FATHER'S NAME FIRST MIDDLE LAST: Daniel Hardesty

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mary Katherine Drury

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 578-01-7453A

17. INFORMANT: James A. Hardesty

ADDRESS: 7702 Sondra Ct. New Carrollton MD 20784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Brain metastasis

DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung ca

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): hypertension prostatic hypertrophy prostatectomy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from Nov 26, 19 87 to Feb 26, 19 87, that I (we) last saw the deceased alive on Feb 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE

ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4/8/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LEWIS DENNIS M.D.

22e. ADDRESS: 831 University Blvd. Sil. Spg Md. 20903

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/11/87

23c. NAME OF CEMETERY OR CREMATORY: Washington Natl Cem

23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland Prince George's Md

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc.

ADDRESS: Old ALexander Ferry Rd Clinton Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining pages behind page 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified of the death.

BP

DHMH - 16 60M 7/84 (VRA 15.6)

6633

044142 FEB 17 87

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05409
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ruth — MIDDLE: E. — LAST: Harrell
2a. DATE OF DEATH — MONTH DAY YEAR: 2-12-1987
2b. HOUR: 5 AM M
3. SEX: Female.
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: 11-6-1892
6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Catlett Va.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Bethesda.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Gros Venr Heath Care Center.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: MONT.
13c. CITY OR TOWN: TAKOMA PARK
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS / ZIP CODE: 26 LEE AVENUE 20912

14. FATHER'S NAME — FIRST: JAMES — MIDDLE: — LAST: THORPE
15. MOTHER'S MAIDEN NAME — FIRST: — MIDDLE: — LAST: ROBINSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-58-6655
17. INFORMANT: FAMILY RECORDS ON FILE — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiopulmonary Arrest — 2/12/1987
DUE TO, OR AS A CONSEQUENCE OF (b) CVA — 1986
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD — 1986

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☑
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 10/6/86, 19__, to 2/12/87, 19__, that (I) ~~(we)~~ last saw the deceased alive on 2/11/87, 19__, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ did ~~did not~~ view the body after death.

22b. SIGNATURE: G B Patrick III MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/12/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): G B Patrick III MD
22e. ADDRESS: 9221 Colesville Rd Silver Spring, Md 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 16. 1987
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION — CITY OR TOWN: Rockville — COUNTY: — STATE: Md

24. FUNERAL DIRECTOR — NAME: Takoma Funeral Home J. Walter — ADDRESS: 25 Carroll Ave
25a. DATE REC'D. BY REGISTRAR: FEB 17 1987
25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

043883 FEB 3 67

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05 410

1. DECEASED NAME (TYPE OR PRINT): FIRST F. MIDDLE Lucille LAST Harris

2a. DATE OF DEATH: MONTH 02 DAY 05 YEAR 87

2b. HOUR 11:13 A M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 01 DAY 19 YEAR 00

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Teacher.

12b. KIND OF BUSINESS OR INDUSTRY: DC Public School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 314 Hillmoor Dr. 20901

14. FATHER'S NAME: FIRST Samuel MIDDLE R. LAST Harris

15. MOTHER'S MAIDEN NAME: FIRST Charity MIDDLE LAST Batten

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 220-44-2137T

17. INFORMANT: Robert Miley-cousin- ADDRESS: 8924 Anna Drive Clinton, Md. 20735

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL INSUFFICIENCY, ARTERIOSCLEROTIC VASC. DISEASE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 87, to Feb 5, 19 87, that I (we) last saw the deceased alive on Feb 5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bernard A Fitzgerald

DEGREE: MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-5-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BERNARD A FITZGERALD

22e. ADDRESS: 217 University Blvd E, Silver Spring, Md 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-7-1987

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION: CITY OR TOWN Suitland COUNTY Prince Georges STATE Md

24. FUNERAL DIRECTOR: Hines-Rinaldi Funeral Home ADDRESS: 11800 N.H. Ave., Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 11 1987

25b. REGISTRAR'S SIGNATURE: Julia Perkins Rudner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045186 FEB 20 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05411
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sarah MIDDLE: Edith LAST: HAWTHORNE

2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 18 1987

2b. HOUR: 12:00 PM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH MONTH DAY YEAR: June 28, 1912

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 42 West Deer Park Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales

12b. KIND OF BUSINESS OR INDUSTRY: Retail

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 42 West Deer Park Drive 20877

14. FATHER'S NAME FIRST: John MIDDLE: LAST: Forrester

15. MOTHER'S MAIDEN NAME FIRST: Eveline MIDDLE: LAST: Profitt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 225-30-8856

17. INFORMANT: Sarah Joan Hill

ADDRESS: 5024 Mt.Zion Road Frederick, MD 21701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma — 4 months

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Emboli, Asymmetric Septal Hypertrophy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from NOVEMBER, 19 86, to FEBRUARY, 19 87, that (I) ~~(we)~~ last saw the deceased alive on FEBRUARY 10, 19 87, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: Jules R. Lodish — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JULES R. LODISH

22e. ADDRESS: 2901 OLNEY-SANDY SPRING RD., OLNEY, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 20, 1987

23c. NAME OF CEMETERY OR CREMATORY: Poplar Spring United Meth. Church Cem.

23d. LOCATION CITY OR TOWN: Poplar Spring, Maryland COUNTY STATE

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc.

ADDRESS: 300 West Montgomery Ave. Rockville, MD

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of each.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

046532 MD

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 053 12
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rachel MIDDLE: James LAST: Haydn

2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1987

2b. HOUR: 8:15P M

3. SEX: Female

4. RACE: CAucasian

5. DATE OF BIRTH MONTH DAY YEAR: March 2, 1903

6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Virginia ~~Richardsville~~

13b. COUNTY: Culpeper

13c. CITY OR TOWN: Richardsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: Box 18 22736

14. FATHER'S NAME FIRST: James MIDDLE: A. LAST: Boals

15. MOTHER'S MAIDEN NAME FIRST: Eliza MIDDLE: Martin LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 577-10-1698

17. INFORMANT: Mrs. Carol Lee Lintz, ADDRESS: 13814 Wayside Drive, Clarksville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1HR

DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE. — 1 DAY

DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA. — 1 DAY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CARDIAC ARRYHTHMIA CHF HYPOTHYROIDISM, CVA, HYPOTENSION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (the hospital) attended the deceased from 2/19 19 87 to 2/19 19 87, that (I) (we) last saw the deceased alive on 2/19 19 87, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RAVI PASSI MD

22e. ADDRESS: 11141 GEORGIA AVE. SUITE 104 WHEATON, MD. 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/23/87

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria Virginia

24. FUNERAL DIRECTOR NAME: Wheeler & Thompson, Inc., ADDRESS: 705 P. A. St. Fredericksburg, Virginia

W. B. Snellings

25a. DATE REC'D. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

45259

59 FEB 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 87 05 413

1. DECEASED NAME (TYPE OR PRINT) FIRST SETTLE MIDDLE (nOne) LAST HEADLEY

2a. DATE OF DEATH MONTH 02 DAY 18 YEAR 87

2b. HOUR 2:58 P.M.

3. SEX MALE

4. RACE WHITE

5. DATE OF BIRTH MONTH 10 DAY 21 YEAR 11

6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.

10. CITY OR TOWN OF DEATH BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treasury Depart.

12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Montgomery

13c. CITY OR TOWN Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE 5301 Westbard Circle 20816

14. FATHER'S NAME FIRST Yarrett MIDDLE Richard LAST Headley

15. MOTHER'S MAIDEN NAME FIRST Lila MIDDLE LAST Settle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) WW II

16b. SOCIAL SECURITY NO. 577-60-0450

17. INFORMANT ADDRESS Anne B. Headley (Wife) same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest.	One Hour
DUE TO, OR AS A CONSEQUENCE OF (b)	Ventricular Fibrillation	one hour
DUE TO, OR AS A CONSEQUENCE OF (c)	Hypertensive C-V Disease	5 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to present, 19____, that (I) (we) last saw the deceased alive on 18 Feb. 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Harold D. Cures MD DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 18 Feb. 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD. I. PASSES M.D.

22e. ADDRESS 3701 Mass Ave Washington DC 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE Feb. 21, 1987

23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery

23d. LOCATION CITY OR TOWN Crownsville, COUNTY Maryland STATE

24. FUNERAL DIRECTOR NAME John F. DeVol ADDRESS DeVol Funeral Home 2222 Wisc. Ave., NW Wash. DC

25a. DATE REC'D. BY REGISTRAR FEB 24 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Taber M.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial-transit permit. Then please remove the perforated stub on pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

043782 FEB 1 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05414

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Diana — MIDDLE: Hines — LAST: Heard

2a. DATE OF DEATH — MONTH DAY YEAR: February 3, 1987

2b. HOUR: 845 AM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: April 12, 1930

6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Public School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 9459 Horizon Run Road 20760

14. FATHER'S NAME — FIRST: Wendell — MIDDLE: R. — LAST: Heard

15. MOTHER'S MAIDEN NAME — FIRST: Mabelle — MIDDLE: — LAST: Hines

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 246-44-7291

17. INFORMANT: Mabelle H. Heard — ADDRESS: 1329 Second Street Gulfport, Miss. 39501

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	1 minute
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Respiratory Distress Syndrome	20 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Hemophilus influenza Pneumonia	23 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal failure (acute), G.I. bleed, Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (~~XXXXXX~~) attended the deceased from January 14, 19 87, to February 3, 19 87, that (I) (☒) last saw the deceased alive on February 3, 19 87, and that in (my) (☒) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE: Lee R. Pennington, MD — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. 3, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lee R. Pennington, MD

22e. ADDRESS: #414 8218 Wisconsin Ave. Bethesda, Maryland 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 6, 1987

23c. NAME OF CEMETERY OR CREMATORY: Southern Memorial Park

23d. LOCATION — CITY OR TOWN: Biloxi — COUNTY — STATE: Mississippi

24. FUNERAL DIRECTOR — NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. — ADDRESS: Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: FEB 9 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Sanders

044023 FEB 17 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05415
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Joseph MIDDLE Anthony LAST Heberle

2a. DATE OF DEATH: MONTH Feb DAY 4 YEAR 1987

2b. HOUR: 12 50 A.M.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 12 DAY 10 YEAR 99

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minn.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist

12b. KIND OF BUSINESS OR INDUSTRY: Navil Gun Factory

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 1001 Spring St. #218 20910

14. FATHER'S NAME: FIRST Joseph MIDDLE Anton LAST Heberle

15. MOTHER'S MAIDEN NAME: FIRST Walburga MIDDLE LAST Reichert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-58-4737

17. INFORMANT: Elizabeth Heberle ADDRESS: wife same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive pulmonary disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I / this hospital) attended the deceased from 1/21/87, 19__, to 2/4, 19 87, that (I / we) last saw the deceased alive on 2/4, 19 87, and that in (my / our) opinion death occurred on the date and hour and from the causes stated above. (I / we) did (did not) view the body after death.

22b. SIGNATURE: James H. Brodsky DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James H. Brodsky

22e. ADDRESS: 4701 Willard Ave Chevy Chase MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 6, 1987

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION: CITY OR TOWN Suitland COUNTY Prince Georges STATE Md.

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the remaining pages in carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or if death was a violent or suspicious event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

Items, 18a., 18b.&18c., was told to leave blank, and also to delete inf.; also 21c., / G-627, 5/28/87, Gbj.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05416
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Millard MIDDLE: P. LAST: Helton JR		2a. DATE OF DEATH MONTH DAY YEAR: 2/6/87	2b. HOUR: 3:45PM
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: AUG. 12, 1927	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TENN.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP'T.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PLUMBER	12b. KIND OF BUSINESS OR INDUSTRY: PLUMBING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
UNK.	UNK.	UNK.	YES ☒ NO ☐	UNKNOWN 99999

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
MILLARD	P.	HELTON SR.	THELMA		CARPENTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	412-28-3088	BELINDA S. ENGELS	13301 ARDENNES AVE. ROCKVILLE, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Head injury (subdural-hematoma)

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

888

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease, chronic alcoholism with seizure disorder, ~~Hepatic Encephalopathy, Recent Subdural Hematoma~~

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☒

21b. TIME OF INJURY unknown HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Forrestville, Md.

21f. LOCATION STREET unknown CITY OR TOWN COUNTY STATE

21c. subject possibly fell.

22a. I certify that (I) (~~the hospital~~) attended the deceased from 2-3, 19 87 to 2-6, 19 87, that (I) (~~we~~) last saw the deceased alive on 2/6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas J. Locke III — 22e. ADDRESS: 8580 Second Ave Silver Spring, Md. 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	2-9-1987	CHAMBERS CREMATORY	RIVERDALE,	P.G.C.	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO. INC.	SILVER SPRING, Md. 20910	FEB 13 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completely filled in by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then, page 3 should be forwarded to the local registrar or urban papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If there is no medical or legal reason to suspect any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH 16 60M 7/84 (VRA 15, 4)

Mrs. K. OK. to delete the correction 5/28/87

04417 FEB 17 87

Relayed by Medical Examiner

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 054 1240 pm

044002 FEB 1987

1. DECEASED NAME (TYPE OR PRINT): FIRST RUTH; MIDDLE Elsie; LAST HENDRICKS

2a. DATE OF DEATH: MONTH Febry; DAY 12; YEAR 1987

2b. HOUR: 0040 M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH Feb.; DAY 28; YEAR 1923

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.; IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Bluefield West Va

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Educator

12b. KIND OF BUSINESS OR INDUSTRY: Board of Ed.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P. G.

13c. CITY OR TOWN: Clinton

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 5403 Chris-Mar Ave. 20735

14. FATHER'S NAME: FIRST Walter; MIDDLE J.; LAST Hendricks

15. MOTHER'S MAIDEN NAME: FIRST Ristina; MIDDLE; LAST Lee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 235-34-8826

17. INFORMANT: Anne L Jones

ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral nervous system hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoproliferative disorder of marrow

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 87 to 10/86 19 87 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Marlen O. Weltzer

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/12/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Weltz

22e. ADDRESS: 7525 Greenway Cir Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/17/87

23c. NAME OF CEMETERY, CREMATORY: Forest Hills Mem. Gardens

23d. LOCATION: CITY OR TOWN Clinton; COUNTY Prince George's; STATE Md

24. FUNERAL DIRECTOR: NAME Lee Funeral Home, Inc.; ADDRESS Old Alexander Ferry Rd. Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove copies 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state (one copy to be retained at office).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

DHMH - 16 60M-7-84 (VRA 15, 4) 6633

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 05418
REG. NO.

045145 FEB 27

1. DECEASED NAME (TYPE OR PRINT): FIRST KENNETH MIDDLE S. LAST HESS

2a. DATE OF DEATH: MONTH 02 DAY 22 YEAR 87

2b. HOUR: 2030 M

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH Sept. DAY 6, YEAR 1916

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County, MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanical Contracting/

12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: BETHESDA

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 5509 LAMBETH RD 20814

14. FATHER'S NAME: FIRST Fred MIDDLE G. LAST Hess

15. MOTHER'S MAIDEN NAME: FIRST Hattie MIDDLE B. LAST Brasse

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 578-14-0520

17. INFORMANT: Doris B. Hess, Same as # 13. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial ischemia — Minutes

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JAN 1984 to 22 Feb 1987 that (I) (we) last saw the deceased alive on NOV 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert T Kelley M

DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 22 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT T KELLEY

22e. ADDRESS: 8218 WISCONSIN AVE, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 25, 1987

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (CITY OR TOWN): Silver Spring COUNTY Maryland

24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase/ Inc. ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland 20814

25a. DATE REC'D BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE: Julia Dixon-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, on back (B) should be completed. For any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Md Medical Examiner 2-22-87

BP

DHMH - 16 60M 7/
(VRA 15, 4)

45125 FEB 26

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 19
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: EUNICE MIDDLE: J. LAST: HESSICK

2a. DATE OF DEATH MONTH DAY YEAR: Feb 20 1987

2b. HOUR: 12⁰¹ A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Oct. 6, 1910

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CARRIAGE HILL-BETHESDA

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Office Manager

12b. KIND OF BUSINESS OR INDUSTRY: Developers

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 4948 Sentinal Road 20816

14. FATHER'S NAME FIRST: John MIDDLE: LAST: Johnson

15. MOTHER'S MAIDEN NAME FIRST: Viola MIDDLE: LAST: Harris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: unavailable

17. INFORMANT: Son-William H. Hessick III ADDRESS: 5012 Balton Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic carcinoma

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of uterus

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug. 5, 1986, to present, 19____, that (I) (we) last saw the deceased alive on Feb. 13, 1987, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 23 '87

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Washington, m D.C.

24. FUNERAL DIRECTOR NAME: James DeVol ADDRESS: DeVol Funeral Home Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE: Julia Bendon-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death to remove carbon papers. Pages 1 and 2 should be filed with the medical examiner, the medical examiner must be notified at once of cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows death by other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045372 FEB 25 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 420
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Freddie General Hicks		2a. DATE OF DEATH MONTH DAY YEAR: 14 Feb 1987	2b. HOUR: 8:12P M
3. SEX: Male	4. RACE: Negroid	5. DATE OF BIRTH MONTH DAY YEAR: Aug 14 1916	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Naval Hospital, Bethesda	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tax Advisor	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
No. Carolina	Craven	New Bern	YES ☒ NO ☐	515 Elder Street 28560

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
James Miles Hicks	Emma Eliza Brooks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		238-18-7375	Iris Thomasina Stevens	5301 Thunderhill Rd. Columbia, Md. 21045

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Aspiration of Gastric contents

DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma

DUE TO, OR AS A CONSEQUENCE OF (c)

911

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 15, 19 86, to FEBRUARY 14, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Thomas A Dowgin	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	16 Feb 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
THOMAS A. DOWGIN MD	NH Bethesda MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02-19-87	Meadows Cemetery	New Bern	Craven	N.C.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert G. Mason	1661 Good Hope Road, S.E.	FEB 24 87	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

045710 FGR.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17 FOR STATE REGISTRAR — REG. NO. 0 5 4 2 1

1. DECEASED NAME (TYPE OR PRINT): FIRST Donna MIDDLE L. LAST Higginson

2a. DATE OF DEATH KNOWN / ESTIMATED: MONTH Feb DAY 28 YEAR 87 — 2b. HOUR 11:00 AM

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 28 YEAR 87 — 2d. HOUR 11:13 AM

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: MONTH Aug DAY 5 YEAR 51 — 6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rhode Island — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Sil. Spg. — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A — 12b. KIND OF BUSINESS OR INDUSTRY: N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Prince Georges — 13c. CITY OR TOWN: Laurel — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 15616 Carraige Hill Lane 20707

14. FATHER'S NAME: FIRST Arthur MIDDLE H. LAST Higginson — 15. MOTHER'S MAIDEN NAME: FIRST Betty MIDDLE N. LAST Jensen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: N/A — 17. INFORMANT: Arthur Higginson — ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Seizure Disorder

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY) Dep. MEDICAL EXAMINER — DATE SIGNED Feb 28, 1987

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers MD — ADDRESS 1919 Seminary Rd. Sil. Spg. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 03/03/87 — 23c. NAME OF CEMETERY OR CREMATORY: Washington National Cem. — 23d. LOCATION CITY OR TOWN: Suitland COUNTY: Prince George's STATE: Md.

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. — ADDRESS: 6633 Old Alexander Ferry Rd. Clinton, Md 20735 — 25a. DATE REC'D. BY REGISTRAR: MAR 02 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Brodie

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M — BP ____ — DHMH - 17 (VR A15 ME (5))

045263 FEB 26 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05422
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: EVELYN — MIDDLE: D. — LAST: HILL

2a. DATE OF DEATH — MONTH: FEBRUARY — DAY: 19 — YEAR: 1987

2b. HOUR: 1:00PM

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH — MONTH: Jan. — DAY: 10 — YEAR: 1907

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: GAITHERSBURG

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HERMAN WILSON HEALTH CARE CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEACHER

12b. KIND OF BUSINESS OR INDUSTRY: EDUCATION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: GAITHERSBURG

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 401 Russell Ave. #312 20877

14. FATHER'S NAME — FIRST: NICHOLAS — MIDDLE: – — LAST: DASHIELLS

15. MOTHER'S MAIDEN NAME — FIRST: ANNA — MIDDLE: G. — LAST: (UNKNOWN)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-34-0103A

17. INFORMANT: Walter L. Hill, Sr. — ADDRESS: Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adeno-carcinoma, endometrial, metastatic

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: March 6, 85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: As above

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 82, to 2-19-87 19____, that (I) (we) last saw the deceased alive on 2-19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jack Schumacher — DEGREE: M.D. — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-19-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. JACK SCHUMACHER

22e. ADDRESS: GAITHERSBURG, MD. 20877

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB. 23, 1987

23c. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE CEMETERY

23d. LOCATION — CITY OR TOWN: PIKESVILLE — COUNTY: BALTIMORE — STATE: MD.

24. FUNERAL DIRECTOR: MURIEL H. BARBER LAYTONSVILLE, MD. 20879

25a. DATE REC'D BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then place remaining pages, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

046299
6299 MAR -9 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05423
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MALACHI MIDDLE: H. LAST: HILL

2a. DATE OF DEATH MONTH DAY YEAR: 2/28/87

2b. HOUR: 1 40 P.M.

3. SEX: MALE

4. RACE: BLACK

5. DATE OF BIRTH MONTH DAY YEAR: 05 07 22

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NO CAROLINA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BEL PRE HEALTH CARE CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver

12b. KIND OF BUSINESS OR INDUSTRY: Private Firm

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE:

13b. COUNTY:

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS / ZIP CODE: 1260 half St S.E. 99999

14. FATHER'S NAME FIRST: MALACHI MIDDLE: H. LAST: Hill Sr

15. MOTHER'S MAIDEN NAME FIRST: Bessie MIDDLE: LAST: Herrion

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 579-16-5822

17. INFORMANT: Richard Hill ADDRESS: 2419 Savannah Street, S.E Washington, DC 20020

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (b) Dementia

DUE TO, OR AS A CONSEQUENCE OF (c) Post CVA. (3 mo.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov. 3, 19 86, to Feb. 28, 19 87, that ~~I~~ (we) last saw the deceased alive on Feb 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Raymond Bradshaw, MD. DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. 28, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Raymond Bradshaw, MD

22e. ADDRESS: 345 University Blvd, W Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: MAR 7, 1987

23c. NAME OF CEMETERY OR CREMATORY: Washington National

23d. LOCATION CITY OR TOWN: Suitland COUNTY: P.G. STATE: Maryland

24. FUNERAL DIRECTOR NAME: E.M. Dudley & Sons Funeral Home ADDRESS: 3200 Rhode Island Ave. Mt. Rainier, Md

25a. DATE REC'D. BY REGISTRAR: MAR 05 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

999999

BP

DHMH - 16,60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When physical remains are to be cremated, page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

1

046293 MAR 0 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 5 4 2 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST SAN SAN MIDDLE T. LAST HLA

2a. DATE OF DEATH: MONTH 2 DAY 28 YEAR 87

2b. HOUR: 2:30 AM

3. SEX: FEMALE

4. RACE: ORIENTAL

5. DATE OF BIRTH: MONTH JAN. DAY 24, YEAR 1936

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BURMA

7b. CITIZEN OF WHAT COUNTRY?: BURMA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: ROCKVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST HOSP.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ASSEMBLY TECHNICIAN

12b. KIND OF BUSINESS OR INDUSTRY: FAIRCHILD INDUSTRIES

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: GERMANTOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 11520 DOXDAM TERR. / 20874

14. FATHER'S NAME: FIRST UNYO MIDDLE — LAST LAN

15. MOTHER'S MAIDEN NAME: FIRST DAW MIDDLE HLA SHIM LAST Oo

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): NONE

16b. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: U.T. HLA (HUSBAND) ADDRESS: SAME AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Metastatic lung cancer
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 87, to 2/28, 19 87, that (I) (we) last saw the deceased alive on 2/28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN G. LODMELL, MD

22e. ADDRESS: 2801 Olney Sandy Spring Rd. Olney MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: MARCH 2, 1987

23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY

23d. LOCATION: CITY OR TOWN RIVERDALE COUNTY P.G. CO. STATE MARYLAND

24. FUNERAL DIRECTOR: NAME CHAMBERS FUNERAL HOME ADDRESS SILVER SPRING, MARYLAND

25a. DATE REC'D. BY REGISTRAR: MAR 06 1987

25b. REGISTRAR'S SIGNATURE

045329 FEB 26 87

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05425
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SARAH MIDDLE: LAST: HOFFMAN		2a. DATE OF DEATH MONTH DAY YEAR: 02 13 87	2b. HOUR: 8.39 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 10, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLERK	12b. KIND OF BUSINESS OR INDUSTRY: US GOVERNMENT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	ROCKVILLE	YES ☒ NO ☐	6121 MONTROSE ROAD 20852

14. FATHER'S NAME FIRST: (UNASCERTAINABLE) MIDDLE:	LAST: (UNASCERTAINABLE)	15. MOTHER'S MAIDEN NAME FIRST: (UNASCERTAINABLE) MIDDLE:	LAST: (UNASCERTAINABLE)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 569-01-3159	17. INFORMANT (NAME, RELATIONSHIP, ADDRESS): HARRY E. KAPLAN, 1106 ROSWELL DRIVE SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA — 2 Days

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER

DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LEFT BREAST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/9/ 1984 to 2/13/ 1987, that (I) (we) last saw the deceased alive on 2/13/ 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If death occurred did not view the body after death.)

22b. SIGNATURE: D D Patel	DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 2/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL, M.D.	22e. ADDRESS: 6121 MONTROSE RD, ROCKVILLE MD	

23a. BURIAL, CREMATION, REMOVAL: BURIAL	23b. DATE: 2/15/1987	23c. NAME OF CEMETERY OR CREMATORY: MOUNT LEBANON CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ADELPHI, PRINCE GEORGE'S, MARYLAND
24a. FUNERAL DIRECTOR NAME / ADDRESS: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D BY REGISTRAR: FEB 19 1987	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return items 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

045931 MAR 4 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05 426

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: C LAST: HOLT

2a. DATE OF DEATH MONTH DAY YEAR: 2 21 87

2b. HOUR: 8p M

3. SEX: Female

4. RACE: W

5. DATE OF BIRTH MONTH DAY YEAR: 10 06 00

6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): L.P. NURSE

12b. KIND OF BUSINESS OR INDUSTRY: NURSING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: md

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2111 HILDAROSE DRIVE #104 20902

14. FATHER'S NAME FIRST: WILLIAM MIDDLE: E. LAST: Claybrook

15. MOTHER'S MAIDEN NAME FIRST: KATE MIDDLE: LAST: LIPSCOMB

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-40-1468

17. INFORMANT: Funeral Director ADDRESS: 224 Old Maine St. Henderson Funeral Home, Brookneal, Va. 24528

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/21/87, 19____, to 2/21/87, 19____, that (I) (we) last saw the deceased alive on 2/21/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Elsa Martinez (for) Peter Steiner, M.D. DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/21/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELSA J. MARTINEZ, MD

22e. ADDRESS: 8808 Hoover Hill La. - Potomac, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB. 24, 1987

23c. NAME OF CEMETERY OR CREMATORY: MT. CARMEL CEMETERY

23d. LOCATION CITY OR TOWN COUNTY STATE: CHARLOTTE VA.

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIV. BLVD. WEST, SILVER SPRING, MD 20901

25a. DATE RECD. BY REGISTRAR: MAR 02 1987

25b. REGISTRAR'S SIGNATURE: Julia Dandridge-Lindsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the attending physician and completely filled in by the funeral director, page 3 certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84 (VRA 15, 4)

045179 FEB 26 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 054 21
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Morris — MIDDLE: — LAST: Holtz

2a. DATE OF DEATH — MONTH: 2 DAY: 18 YEAR: 87

2b. HOUR: 3:15 pm

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH: August DAY: 15 YEAR: 1903

6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Monument Dealer

12b. KIND OF BUSINESS OR INDUSTRY: Monuments

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 15300 Basswood Court (20853)

14. FATHER'S NAME — FIRST: Unobtainable — MIDDLE: — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Unobtainable — MIDDLE: — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 088-16-6307

17. INFORMANT (NAME, RELATIONSHIP, ADDRESS): Rosilyn Neuder;Daughter;15300 Basswood Ct.; Rockville, Md. 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CEREBROVASCULAR DISEASE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) ~~this hospital~~ attended the deceased from 9/1 19 86 to 2/18 19 87 that (I ~~have~~) last saw the deceased alive on 2/18/87 19 and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated above. (I ~~have~~ did) ~~had my~~ view the body after death.

22b. SIGNATURE: Alan S. Chanales — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN S. CHANALES

22e. ADDRESS: 15225 SHADY GROVE RD ROCKVILLE MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/20/87

23c. NAME OF CEMETERY OR CREMATORY: Wellwood Cemetery

23d. LOCATION — CITY OR TOWN: Pinelawn, L.I., — COUNTY: — STATE: New York

24. FUNERAL DIRECTOR — NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike;Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05428

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nettie	MIDDLE: Viola	LAST: Homer	2a. DATE OF DEATH MONTH DAY YEAR: 02 - 12-87
2b. HOUR: 2:40AM			
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: October 11,1893	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, Maryland
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): National Lutheran Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker	12b. KIND OF BUSINESS OR INDUSTRY: at home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: D.C.	13b. COUNTY: ---	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 5112 Conn. Ave. N.W. 20008			
14. FATHER'S NAME FIRST: William	MIDDLE: B.	LAST: Fry	15. MOTHER'S MAIDEN NAME FIRST: Matilda
MIDDLE:	LAST: Bower		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-84-2740	17. INFORMANT: Rev.Dr.Richard Reichard
ADDRESS: 9701 Veirs Dr Rockville, Md			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Cerebrovascular Syndrome — INTERVAL BETWEEN ONSET AND DEATH: Chronic 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from MAY 1 19 83 to FEB 11 19 87, that (I) (~~we~~) last saw the deceased alive on FEB 10 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: Thomas B. Dodey MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: FEB 12, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas B. Dodey MD

22e. ADDRESS: 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.17,1987	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Maryland
24. FUNERAL DIRECTOR NAME: The Hysong Co.	ADDRESS: 1300 N St.N.W.Wash.D.C.	25a. DATE REC'D BY REGISTRAR: MAR 02 1987	25b. REGISTRAR'S SIGNATURE: Julia Dawson Rankins

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. The cause of death should be entered on the carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", the medical examiner, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 1660M 7/84 (VRA 13, 4)

044749 FEB 20 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page, 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05429

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Herbert W. Hopkins		2a. DATE OF DEATH MONTH DAY YEAR: February 17, 1987	2b. HOUR: 3:50 am
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 30, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Woodbine	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: 2770 Florence Rd. 21797

14. FATHER'S NAME FIRST / MIDDLE / LAST: Henley W. Hopkins	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Musa Edna Davis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-30-6449	17. INFORMANT: Violet R. Hopkins — ADDRESS: Item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic Failure — 4 days

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma to liver — 1 mo

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Colon — 1 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 4, 19 87, to Feb 17, 19 87, that (I) (we) last saw the deceased alive on Feb 16, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Daniel L. Anderson	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	22c. DATE SIGNED: Feb 17, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel L. Anderson, M.D.	22e. ADDRESS: 2901 Olney-Sandy Spring Rd., Olney, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.19,1987	23c. NAME OF CEMETERY OR CREMATORY: Lake View	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Sykesville, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Olin L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 19 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rendace

044525 FEB

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05430
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: JOHN MIDDLE: T LAST: HORTON

2a. DATE OF DEATH — MONTH 2 DAY 12 YEAR 87

2b. HOUR 7:30 P.M.

3. SEX: M Male

4. RACE: White

5. DATE OF BIRTH — MONTH 12 DAY 15 YEAR 01

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales

12b. KIND OF BUSINESS OR INDUSTRY: Retired

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: S.S.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 13500 Colesair Drive 20904

14. FATHER'S NAME — FIRST: Cyrus MIDDLE: Edward LAST: Horton

15. MOTHER'S MAIDEN NAME — FIRST: Sylvania MIDDLE: Ward LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 449 46 0602

17. INFORMANT: Jane Horton (Wife) ADDRESS: Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiogenic shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction — 4 days

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept 19 85 to Feb 12 19 87, that (I) (we) last saw the deceased alive on Feb 12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark S Rosen — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mark S Rosen

22e. ADDRESS: Silver Spring, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/14/87

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION — CITY OR TOWN: Alex. COUNTY / STATE: Va.

24. FUNERAL DIRECTOR: Hines/Rinaldi ADDRESS: 11800 New Hamp.Ave. Silver Spring, Md.

25a. DATE REC'D BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE:

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

044013 FEB 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 0 5 4 3 1

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROBERT MIDDLE: BIGELOW LAST: HOUGHTON		2a. DATE OF DEATH (MONTH DAY YEAR): FEBRUARY 9, 1987	2b. HOUR: 9:50 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH (MONTH DAY YEAR): APRIL 4, 1921	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass.	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Foreign Ser.Officer	12b. KIND OF BUSINESS OR INDUSTRY: US Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
D. C.	---	WASHINGTON	YES [X] NO [ ]	3416 LEGATION ST. NW / 20015

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14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert	B.	Houghton	Helen	--	Wilkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	030-05-1999	LOIS CHAPMAN HOUGHTON (wife)	SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC MALIGNANT MELANOMA TO ANTERIOR MEDIASTINUM, RIGHT AND LEFT NECK

DUE TO, OR AS A CONSEQUENCE OF

(b) PLURAL EFFUSIONS (BILATERAL)

DUE TO, OR AS A CONSEQUENCE OF

(c) PEPTIC ULCERATION WITH GASTRO INTESTINAL HEMORRHAGE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

SUPERIOR VENA CAVAL SYNDROME

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (X) (this hospital) attended the deceased from December 2, 19 86, to February 9, 19 87, that (X) (we) last saw the deceased alive on February 9, 19 87, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Roberta E Lee	MD	STAFF PHYSICIAN [X]	2-9-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Roberta E Lee	NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/10/87	Mt. Comfort Crematory	Alexandria, VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc.	5130 Wisconsin Ave,NW,Washington,D.C. 20016	FEB 13 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

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BP

DHMH - 16 60M 7/84 (VRA 15, 4)

Item # 7b & 14, Film G 624 2/26/87 ra

044010 FEB 17 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05 432

1. DECEASED NAME (TYPE OR PRINT): FIRST Marjorie MIDDLE D. LAST Hoy
MARJORIE D. HOY

2a. DATE OF DEATH: MONTH 2 DAY 5 YEAR 87
2b. HOUR 6 35 AM

3. SEX: FEMALE
4. RACE: CAUC
5. DATE OF BIRTH: MONTH 01 DAY 28 YEAR 1898
6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada
7b. CITIZEN OF WHAT COUNTRY? ~~Canada~~ U.S..A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montg. MD.

10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: GA
13b. COUNTY: Stephens
13c. CITY OR TOWN: Toccoa
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 121 Glencrest Dr./30577

14. FATHER'S NAME: FIRST ~~Edwin~~ Harry MIDDLE -- LAST Day
15. MOTHER'S MAIDEN NAME: FIRST Jane MIDDLE -- LAST Dane

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ---
16b. SOCIAL SECURITY NO.: 260-74-1345
17. INFORMANT: Jane H. Roberts, ADDRESS 4705 Dorset Ave, Chevy Chase, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 MINS
DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Sepsis; urinary tract infection

19a. DATE OF OPERATION: 2/4/87
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: arterial embolus to (L) leg
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4 19 87, to 2/5 19 87 that (I) (we) last saw the deceased alive on 2/5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Louis Kozloff
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Louis Kozloff, M.D.
22e. ADDRESS: 8218 Wisconsin Ave. Bethesda, MD. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 2/9/87
23c. NAME OF CEMETERY OR CREMATORY: Mt. Cpmfort Crematory
23d. LOCATION: CITY OR TOWN Alexandria, VA COUNTY STATE

24. FUNERAL DIRECTOR: NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016
25a. DATE REC'D BY REGISTRAR: FEB 13 1987
25b. REGISTRAR'S SIGNATURE

999999 BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please [illegible] the newspapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

043781 FEB

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05433

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: G. LAST: Hrindac		2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1987	2b. HOUR: 10:40 A.M.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 1, 1898	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Coal Miner	12b. KIND OF BUSINESS OR INDUSTRY: Mining

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Penna.	Washington	Muse	YES ☒ NO ☐	32 Locust Street/15350

14. FATHER'S NAME FIRST: Michael MIDDLE: LAST: Hrindac		15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: LAST: Shraga	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 193-10-1636	17. INFORMANT: William G. Hrindac ADDRESS: 8005 Park Lane Bethesda, MD 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-pulmonary Arrest	Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Alzheimers Disease	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinson Disease Urinary tract infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from July, 1980 to Feb. 4, 1987, that (I) (we) last saw the deceased alive on Feb. 3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William H. Killay	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb. 4, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): William H. Killay, M.D.	22e. ADDRESS: 8218 Wisconsin Avenue Bethesda, Maryland 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY: Oak Spring Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Canonsburg, Pennsylvania
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.	ADDRESS: 7557 Wisconsin Ave. Bethesda, MD 20814	STATE REGISTRAR RECEIPT: FEB 9 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Medical examiner cases must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045333 FEB 26 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 0 5 4 3 4

1. DECEASED NAME (TYPE OR PRINT): FIRST Nancie MIDDLE Lynn LAST Huckins

2a. DATE OF DEATH: MONTH February DAY 14 YEAR 1987

2b. HOUR: 05:10am

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH August DAY 4 YEAR 1958

6. AGE (IN YEARS LAST BIRTHDAY): 28 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, The Clinical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Virginia

13b. COUNTY:

13c. CITY OR TOWN: Alexandria

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 3222 S. 28th St., #403 22302

14. FATHER'S NAME: FIRST Wayne MIDDLE LAST Downer

15. MOTHER'S MAIDEN NAME: FIRST Susan MIDDLE LAST Blanford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 261-41-1207

17. INFORMANT: Larry E. Huckins, Husband ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Subcapsular hepatic hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic adrenal cortical carcinoma

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (X) (this hospital) attended the deceased from February 11, 19 87, to February 14, 19 87, that (X) I (we) last saw the deceased alive on February 14, 19 87, and that in (X) my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (X) (not) view the body after death.

22b. SIGNATURE: Robert E Fromm MD DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 2/14/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT E FROMM JR MD

22e. ADDRESS: National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/17/87

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION: CITY OR TOWN Daytona Beach COUNTY STATE Florida

24. FUNERAL DIRECTOR: NAME Murphy Fun'l Home ADDRESS 4510 Wilson Blvd. Arl. Va.

25a. DATE REC'D BY REGISTRAR: FEB 20 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Page 4 must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 60M 7/84 (VRA 15, 4)

044020 FEB 17 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 - 05435

1. DECEASED NAME (TYPE OR PRINT) First: Lorraine Middle: Teresa Last: Huekels		2a. DATE OF DEATH Month: February Day: 8 Year: 87	2b. HOUR 9:50 A.M.
3. SEX: female	4. RACE: Caucasian	5. DATE OF BIRTH Month: December Day: 4 Year: 1927	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kensington Gard. Nsg	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: I.R.S.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Wheaton	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 12025 Veirs Mill Rd Apt 101 20902
14. FATHER'S NAME First: Louis Middle: Last: Manarin		15. MOTHER'S MAIDEN NAME First: Mary Middle: Last: Urbanek	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-34-2567	17. INFORMANT: Karen Huekels	ADDRESS: daughter same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiorespiratory arrest	1 min
DUE TO, OR AS A CONSEQUENCE OF (b)	lung cancer	7 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6/13, 19 86, to 2/8, 19 87, that (I) (we) last saw the deceased alive on 2/2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bruce A. Silver, MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2/9/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRUCE A. SILVER	22e. ADDRESS: 106 Irving St., N.W., Wash, DC 20010	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rockville Montgomery Maryland
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 13 1987	25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the medical examiner page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/84 (VRA 15, 4)

045678 MAR 27

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, [illegible] or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05436

1a. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Woodrow W. Hungerford		2a. DATE OF DEATH MONTH DAY YEAR: 02 25 87	2b. HOUR: 12:42AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JAN. 5, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BULL DOZER OPER.	12b. KIND OF BUSINESS OR INDUSTRY: SAWMILL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	MONT.	SILVER SPRING	YES ☐ NO ☒	10120 New Hampshire Ave. 20903

14. FATHER'S NAME FIRST / MIDDLE / LAST: WILLIAM C. HUNGERFORD		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: LILLIAN - (UNKNOWN)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-12-3273	17. INFORMANT / ADDRESS: MARY A. FURR SAME AS # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 40 min.

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced obstructive Lung Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb. 20, 19 86, to Feb. 25, 19 87, that (I) (we) last saw the deceased alive on Feb. 24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frank J. Mayo	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-25-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frank J. Mayo, MD		22e. ADDRESS: 16220 Frederick Rd. #213 Gaithers	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY: UPPER SENECA BAPTIST	23d. LOCATION CITY OR TOWN / COUNTY / STATE: CEDAR GROVE, MONT. MD.
24. FUNERAL DIRECTOR / ADDRESS: MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR: FEB 27 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudacs

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05437

043291

1. DECEASED NAME (TYPE OR PRINT): FIRST Lillian MIDDLE H. LAST Hutchins

2a. DATE OF DEATH: MONTH DAY YEAR February 3, 1987

2b. HOUR 1:40A M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH DAY YEAR Oct. 1, 1898

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Potomac Valley Nursing Center

12a. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE): Telephone Operator

12b. KIND OF BUSINESS OR INDUSTRY: Justice Dept.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince George's

13c. CITY OR TOWN: Hyattsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2600 Queens Chapel Road 20782

14. FATHER'S NAME: FIRST George MIDDLE H. LAST Harrell

15. MOTHER'S MAIDEN NAME: FIRST Ada MIDDLE L. LAST Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216 40 7029

17. INFORMANT: Niece ADDRESS: 19325 Dunbridge Way Gaithersburg MD Catherine Talcott

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uro Sepsis

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebrovascular and Ischemic heart disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11, 19 84, to 2/2/, 19 87, that (I) (we) last saw the deceased alive on 2/2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John R. Melnick

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb 4, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John R. Melnick, M.D.

22e. ADDRESS: 911 N. Russell Ave. Gaithersburg, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 6, 1987

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION: CITY OR TOWN COUNTY STATE Arlington, Virginia

24. FUNERAL DIRECTOR: NAME ROBERT A. PUMPHREY FUNERAL HOME, ROCKVILLE, INC. ADDRESS 300 W. Montg. Ave. Rockville Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 6 1987

25b. REGISTRAR'S SIGNATURE: Julia Davison

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove page 2. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

045067 FEB 25 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05438
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Stuart Howe INGERSOLL, Jr.		2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1987	2b. HOUR: 3:15 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 6, 1939	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): California	7b. CITIZEN OF WHAT COUNTRY?: American	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retail Sales	12b. KIND OF BUSINESS OR INDUSTRY: Store Convenience
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montg.	13c. CITY OR TOWN: Germantown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 14817 Spring Meadows Dr. 20874
14. FATHER'S NAME FIRST MIDDLE LAST: Stuart Howe Ingersoll, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Josephine Sprigman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-54-6077	17. INFORMANT: Debra L. Ingersoll — ADDRESS: Item 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	3 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (b)	METASTATIC CARCINOMA	3 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c)	ADENOCARCINOMA OF THE LUNG	6 MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SPINAL CORD COMPRESSION SYNDROME - EPIDURAL METS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from NOV 11, 1986, to 16 FEB, 1987, that (I) (we) last saw the deceased alive on 16 FEB 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E. P. Libre — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 16 FEB 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EUGENE P. LIBRE MD	22e. ADDRESS: 10400 CONNECTICUT AVE KENSINGTON, MD. 20895	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/17/87	23c. NAME OF CEMETERY OR CREMATORY: Westview Mem. Pk.	23d. LOCATION CITY OR TOWN: Baltimore — COUNTY: Maryland — STATE
24. FUNERAL DIRECTOR NAME: Olin L. Molesworth, P.A. — ADDRESS: Damascus, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 20 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Reinhart

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

046094 MAR 5 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05439
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JUDITH MIDDLE: LAST: ISRAELSON

2a. DATE OF DEATH MONTH DAY YEAR: 2/27/87

2b. HOUR: 3:05 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: 3/18/17

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore, Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk (Retired)

12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY: --------

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 6101 16th Street, N.W. #826 (20011)

14. FATHER'S NAME FIRST: Samuel MIDDLE: LAST: Israelson

15. MOTHER'S MAIDEN NAME FIRST: Sara MIDDLE: LAST: Golomb

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 578-20-5235

17. INFORMANT: Jerome W. Golomb; Counsin; 4511 Q Place, N.W.; Washington, D.C. 20007 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 MIN

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE — 6 MONTHS

DUE TO, OR AS A CONSEQUENCE OF (c) ESSENTIAL HYPERTENSION — 10 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MENTAL RETARDATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from FEB 18, 19 87, to FEB 27, 19 87, that (I) (we) last saw the deceased alive on FEB 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did) (did not) view the body after death.

22b. SIGNATURE: Steven Lipson DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): STEVEN LIPSON

22e. ADDRESS: 6121 MONTROSE ROAD, ROCKVILLE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3/2/87

23c. NAME OF CEMETERY OR CREMATORY: Anshe Niesen Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Rosedale; Baltimore, Maryland

24. FUNERAL DIRECTOR NAME: DANZNASKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: MAR 04 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 999999

DHMH - 16 6M 7/84 (VRA 15, 4)

44583 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05 440

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Robert MIDDLE: W LAST: Jasper, Jr.

2a. DATE OF DEATH — MONTH 02 DAY 08 YEAR 87

2b. HOUR 10:20 P.M.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH 06 DAY 03 YEAR 46

6. AGE (IN YEARS LAST BIRTHDAY): 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Mont. Co. I.S.D.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Gaithersburg

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 24909 Dunnavant Drive 20879

14. FATHER'S NAME — FIRST: Robert MIDDLE: W. LAST: Jasper, Sr.

15. MOTHER'S MAIDEN NAME — FIRST: Val MIDDLE: Jean LAST: Young

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 168-36-7331

17. INFORMANT: brother-in-law — Kevin Grady — ADDRESS: 3718 Queen Mary Drive, Olney, Md. 20832

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Days

DUE TO, OR AS A CONSEQUENCE OF (b) Widely Metastatic Hodgkins Disease — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb. 6, 19 87, to Feb. 8, 19 87, that (I) (we) last saw the deceased alive on Feb. 8, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ADAM BLACKSIN

22e. ADDRESS: 501 N. Frederick Ave., Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 11, 1987

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION — CITY OR TOWN / COUNTY / STATE: Silver Spring Montgomery Md.

24. FUNERAL DIRECTOR — NAME: Francis J. Collins, Jr. — ADDRESS: 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 18 1987

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified, or the death certificate cannot be filed.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

044022 FEB 17 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05441

1. DECEASED NAME (TYPE OR PRINT) FIRST: Daisy MIDDLE: S. LAST: Jennings		2a. DATE OF DEATH MONTH DAY YEAR: Feb. 7, 1987	2b. HOUR: 8 07 AM
3. SEX: F	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 05-12-07	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 3342 Chiswick Ct. 20906
14. FATHER'S NAME FIRST: Harvey MIDDLE: LAST: Sutter		15. MOTHER'S MAIDEN NAME FIRST: Laura MIDDLE: Ellis LAST: Ruby	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-48-0485	17. INFORMANT: son Craig Jennings	ADDRESS: 7 Elmwood Drive Apalachin, N.Y. 13732

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest — Immediate

DUE TO, OR AS A CONSEQUENCE OF (b) Asthma — Long Term

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

887

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Compression Fracture 7th Thoracic Vertebra

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4 Feb, 19 87, to 7 Feb, 19 87, that (I) (we) last saw the deceased alive on 6 Feb, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 7 Feb 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. David Corn	22e. ADDRESS: 18111 Prince Philip Dr. Olney, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria Virginia
24. FUNERAL DIRECTOR NAME: Francis J. Collins, Jr. ADDRESS: 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D BY REGISTRAR: FEB 13 1987	25b. REGISTRAR'S SIGNATURE: Gordon-Landress

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

043 23 FEB 1 87

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 05442
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ARTHUR MIDDLE: E. LAST: Johnson		2a. DATE OF DEATH MONTH DAY YEAR: 2-2-87	2b. HOUR: 1650 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: OCT. 31, 1926	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CANADA	7b. CITIZEN OF WHAT COUNTRY?: CANADA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP'T.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY: P.G.CO.SCHOOL BRD.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P.G.C.	13c. CITY OR TOWN: HYATTSVILLE	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET ADDRESS / ZIP CODE: 6106 40th AVE. 20782
14. FATHER'S NAME FIRST: ALBERT MIDDLE: LAST: JOHNSON		15. MOTHER'S MAIDEN NAME FIRST: MAY MIDDLE: LAST: MALMSTROM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: 377-38-1603	17. INFORMANT: ALICE JOHNSON ADDRESS: (SAME AS ITEM #13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Upper GI Bleeding due to gastritis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Large Cell Carcinoma Lung, Hepatic Encephalopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 84 to 2/2 19 87, that (I) (we) last saw the deceased alive on 2/2 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael Berard MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]		22c. DATE SIGNED: 2/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BERARD.	22e. ADDRESS: 7100 Baltimore Ave College Park Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-5-1987	23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN: BRENTWOOD, COUNTY: P.G.C. STATE: Md.
24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO. ADDRESS: RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR: FEB 9 1987	25b. REGISTRAR'S SIGNATURE: Julia Dorsey-Jordan

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Page 1, 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 05443

1. DECEASED NAME (TYPE OR PRINT) FIRST: FRANCIS MIDDLE: K. LAST: JOHNSON

2a. DATE OF DEATH MONTH DAY YEAR: 2/16/87

2b. HOUR: 2:30 AM

3. SEX: MALE

4. RACE: BLACK

5. DATE OF BIRTH MONTH DAY YEAR: AUG 5 1920

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS

UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: mont MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): WASHINGTON ADVENTIST

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BUS DRIVER

12b. KIND OF BUSINESS OR INDUSTRY: COUNTY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: P.G.

13c. CITY OR TOWN: B.C.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 13122-9th ST 20783

14. FATHER'S NAME FIRST: JAMES MIDDLE: ALBERT LAST: JOHNSON

15. MOTHER'S MAIDEN NAME FIRST: MAGGIE MIDDLE: LAST: CHITTUMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): W.WAR II

16b. SOCIAL SECURITY NO.: 220-05-9381

17. INFORMANT: VAUGHN JOHNSON ADDRESS: 4908 BOWLAND AVE BALTO, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1wk

DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Lung Cancer — 6wks

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): metastatic Prostate Cancer

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital attended the deceased from 1/15/20 19 87 to 2/16 19 87 and that (I/we) last saw the deceased on above date and that death occurred at the date and hour and from the causes stated above. (I) (We) did not view the body after death.

22b. SIGNATURE: Thos A Bensinger MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/16/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas H. Bensinger

22e. ADDRESS: 7625 Greenway Ctr Drive Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB 20 87

23c. NAME OF CEMETERY OR CREMATORY: MD. VET. CEMETERY

23d. LOCATION CITY OR TOWN: CHELTENHAM MD.

24. FUNERAL DIRECTOR NAME: Ryan Hunt Jr. ADDRESS: 7337 Hunt Rd. N.E.

25a. DATE REC'D BY REGISTRAR: FEB 26 1987

25b. REGISTRAR'S SIGNATURE: Julia Dawson-Randolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045240 FEB 26

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 87 05441

1. DECEASED NAME (TYPE OR PRINT): FIRST Haywood MIDDLE J. LAST Jordan

2a. DATE OF DEATH: MONTH February DAY 16 YEAR 1987

2b. HOUR: 5:40A.M.

3. SEX: male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH Jan. DAY 17 YEAR 1913

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. Carolina

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 14000 Castle Blvd. #502

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Insurance Agent

12b. KIND OF BUSINESS OR INDUSTRY: Insurance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 14000 Castle Blvd. #502 20904

14. FATHER'S NAME: FIRST Frank MIDDLE F. LAST Jordan

15. MOTHER'S MAIDEN NAME: FIRST Dora MIDDLE LAST Bryant

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 244-09-1949

17. INFORMANT: Helen Jordan ADDRESS: wife same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/31, 19 84, to 2/16, 19 85, that (I) (we) last saw the deceased alive on 2/12 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/17/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jay Weiner, M.D.

22e. ADDRESS: 4701 Randolph Rd. G-3, Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb. 18 1987

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION: CITY OR TOWN Alexandria COUNTY Virginia

24. FUNERAL DIRECTOR: NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendrick

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The white remote carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

046603 1 8 1987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05445
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: R. LAST: Jordan

2a. DATE OF DEATH MONTH DAY YEAR: 2 28 1987

2b. HOUR: 4 40 P.M.

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH MONTH DAY YEAR: Nov 13 1937

6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Tokoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince George

13c. CITY OR TOWN: Deanwood Pk

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 4811 Deanwood Drive 20855

14. FATHER'S NAME FIRST: Charles MIDDLE: LAST: Graham

15. MOTHER'S MAIDEN NAME FIRST: Alice MIDDLE: Virgnia LAST: Jordan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 577-48-1217

17. INFORMANT: Victoria Jordan ADDRESS: 1112 Elsa Ave Hyattsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 wks
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer — 8 months
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I/this hospital) attended the deceased from 15 April 1986 to 28 Feb 1987 and that (I/we) last saw the deceased alive on 28 Feb 1987 and that in (my/our) opinion death occurred on the date and hour and from the causes stated. I (saw/did) (not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 3/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas A. Benscoter MD

22e. ADDRESS: 7525 Greenway Ctr. Dr. Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Mar 5, 1987

23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Pk

23d. LOCATION CITY OR TOWN: Landover COUNTY: PG STATE: Maryland

24. FUNERAL DIRECTOR NAME: J.B. Jenkins FH ADDRESS: 7474 Landover Rd Landover, Md

25a. DATE REC'D. BY REGISTRAR: MAR 10 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045082 MAR 1 '87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 87 05440

1. DECEASED NAME (TYPE OR PRINT): FIRST John MIDDLE Nick LAST Kalargyros

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR Feb 22 1987 — 2b. HOUR 12 M

3. SEX M — 4. RACE W — 5. DATE OF BIRTH MONTH DAY YEAR March 3 1937 — 6. AGE (IN YEARS) (LAST BIRTHDAY) 37 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Feb 22 1987 — 2d. HOUR 12 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece — 7b. CITIZEN OF WHAT COUNTRY? Greece — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.

10. CITY OR TOWN OF DEATH Sil. Spg. — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk — 12b. KIND OF BUSINESS OR INDUSTRY Greek Embassy

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md — 13b. COUNTY Mont. — 13c. CITY OR TOWN Sil. Spg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS 10834 Eastwood Ave

14. FATHER'S NAME FIRST Nick MIDDLE LAST Kalargyros — 15. MOTHER'S MAIDEN NAME FIRST Angela MIDDLE LAST Agouridis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. 577-78-0978 — 17. INFORMANT Uncle — ADDRESS 10104 Hereford Place

Steve J. Kalargyros, Silver Spring, Md. 20901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) Acute Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertensive Cardiovascular Dis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Severe Rectal Bleeding

19a. DATE OF OPERATION None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. — TITLE (SPECIFY) Dep. MEDICAL EXAMINER — DATE SIGNED Feb 22 1987

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. — ADDRESS 1919 Seminary Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE Feb. 25, 1987 — 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery — 23d. LOCATION CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md.

24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. — ADDRESS 500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR MAR 02 1987 — 25b. REGISTRAR'S SIGNATURE Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

744636 FEB 19 87

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05441
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BERGENE MIDDLE: LAST: KAWIN		2a. DATE OF DEATH MONTH DAY YEAR: 02/15/87	2b. HOUR: 10 AM
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 04 20 19	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WYOMING USA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Rockville MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Physiologist	12b. KIND OF BUSINESS OR INDUSTRY: F.D.A.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Silver Spring	YES XX NO ☐	Dr. (20902) Leslie Kawin;Wife;807 Hillsboro

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Leon		Kawin	Betty		Block

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	557-18-3313	Leslie Kawin;Wife;807 Hillsboro Dr.;	Silver Spring,Md. 20902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest.

DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease Severe

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from H-15 19 85 to 2-15 19 87 that (I) (we) last saw the deceased alive on 2-15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED
Loreto S. Albiol	MD		2-15-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LORETO S. ALBIOL	6121 MONTROSE Rd.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/17/87	Judean Memorial Gdns.	Olney; Montgomery; Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS	1170 Rockville Pike; Rockville, Md. 20852	FEB 18 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the remaining pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

043007 FEB -5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05448

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY MIDDLE: T. LAST: KEARNEY

2a. DATE OF DEATH MONTH: FEBRUARY DAY: 3 YEAR: 87

2b. HOUR: 6:25 A.M.

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH: 11 DAY: 26 YEAR: 14

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS / HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: PRINCE GEORGE

13c. CITY OR TOWN: LANHAM

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 7707 CROSS STREET 20706

14. FATHER'S NAME FIRST: Luigi LAST: Tirendi

15. MOTHER'S MAIDEN NAME FIRST: Eugenia MIDDLE: LAST: Candido

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): - - -

16b. SOCIAL SECURITY NO.: 042-10-4294

17. INFORMANT: Mary S. Chaney

ADDRESS: 6929 Greenvale Parkway Landover Hills, MD 20784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Several

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (or this hospital) attended the deceased from 12/18 19 87, to 2/3 19 87, that I (we) last saw the deceased alive on 2/3 19 87, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/3/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas A. Beatsworth

22e. ADDRESS: 7525 Greenbriar Lake Drive Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: FEB 6, 1987

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION CITY OR TOWN: Arlington STATE: VIRGINIA

24. FUNERAL DIRECTOR NAME: Beall Funeral Home ADDRESS: 16000 Annapolis Road Bowie, MD 20715-3043

25a. DATE REC'D. BY REGISTRAR: FEB 4 - 1987

25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

045993 MAR-4 87

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05449
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Grace MIDDLE: LAST: KELLEY

2a. DATE OF DEATH MONTH DAY YEAR: 2/25/87

2b. HOUR: M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH MONTH DAY YEAR: 2 25 87

6. AGE (IN YEARS LAST BIRTHDAY): YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS 1 MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ XXXXX

BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None

12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: WASH D.C

13b. COUNTY:

13c. CITY OR TOWN: WASHINGTON

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS / ZIP CODE: 216, 17th Place 20002

14. FATHER'S NAME FIRST MIDDLE LAST: Homer Lee

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Caroline Kelley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Non (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: None

17. INFORMANT ADDRESS: Caroline Kelley Mother Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Seven asphyxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary immetority

DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Immetority

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Georgis G Kefale MD DEGREE

ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Georgis G Kefale

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3, March87

23c. NAME OF CEMETERY OR CREMATORY: Washington Nat'L Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Frazier's Funeral Home 389 Rhode Island Avenue Wash, D.C.

25a. DATE REC'D. BY REGISTRAR: MAR 03 1987

25b. REGISTRAR'S SIGNATURE: Julie Bordon Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

999999

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

046029 MAR 4 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05 450
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Shirley MIDDLE: M. LAST: Kelley		2a. DATE OF DEATH MONTH DAY YEAR: 2-22-87	2b. HOUR: 1030AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JULY 12, 1934	6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASS.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP'T.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: AT HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P.G.C.	13c. CITY OR TOWN: BELTSVILLE	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET ADDRESS / ZIP CODE: 4624 BLACKWOOD RD. 20705
14. FATHER'S NAME FIRST: EVERETT LAST: PETERS		15. MOTHER'S MAIDEN NAME FIRST: MARION MIDDLE: LAST: JOHNSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: 024-26-3260	17. INFORMANT: EUGENE B. KELLEY ADDRESS: (SAME AS ITEM #13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma of Lung — 4 months

DUE TO, OR AS A CONSEQUENCE OF (b) Superior Vena Cava Syndrome

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10, 1986, to 2/22, 1987, that (I) (we) last saw the deceased alive on 2/22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/23/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): HARVEY ZIKAZAN	22e. ADDRESS: 8926 Woodyard Rd, Clinton MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-27-1987	23c. NAME OF CEMETERY OR CREMATORY: FOREST HILL CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: HAINES CITY POLK CO., FLA.
24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO. ADDRESS: RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR: MAR 03 1987	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045066 FEB 25 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 054 51

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ROBERT MIDDLE: BLAIR LAST: KENNEDY

2a. DATE OF DEATH — MONTH: FEB. DAY: 18 YEAR: 1987

2b. HOUR: 12 30 AM

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH — MONTH: DEC DAY: 18 YEAR: 1913

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: WHEATON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNIVERSITY NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Iron Worker

12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Pr. Georges

13c. CITY OR TOWN: Oxon Hill

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 7314 Circle Dr. East/20748

14. FATHER'S NAME — FIRST: Alexander MIDDLE: Johnson LAST: Kennedy

15. MOTHER'S MAIDEN NAME — FIRST: Sarah MIDDLE: Idella LAST: Dinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 190-01-9182

17. INFORMANT: Bonnie Gordon — ADDRESS: 504 Captain Dement Dr. Waldorf, Md. 20601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Parkinson's Disease

DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from Jan 3 19 86 to Feb 18 19 87 that ~~I~~ (we) last saw the deceased alive on Feb 18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) (did not) view the body after death.

22b. SIGNATURE: Raymond Bradshaw, Jr. — DEGREE: MD. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Raymond Bradshaw, Jr.

22e. ADDRESS: 345 University Blvd. W Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-20-87

23c. NAME OF CEMETERY OR CREMATORY: Md. Veterans

23d. LOCATION — CITY OR TOWN: Cheltenham COUNTY: Pr. Geo. STATE: Md.

24. FUNERAL DIRECTOR — NAME: Huntt Funeral Home — ADDRESS: P. O. Box 156 Waldorf, Md. 20601

25a. DATE REC'D BY REGISTRAR: FEB 20 1987

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. In such event, the medical examiner [illegible]

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

045210 FEB 25 87

7

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 87 054 52

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH MIDDLE: P LAST: KENRICK

2a. DATE OF DEATH MONTH DAY YEAR: February 20, 1987

2b. HOUR: 11 41 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Sept 24, 1914

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Physician

12b. KIND OF BUSINESS OR INDUSTRY: Medicine

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Chevy Chase

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS / ZIP CODE: 4601 Davidson Drive 20815

14. FATHER'S NAME FIRST: Joseph MIDDLE: P. LAST: Kenrick

15. MOTHER'S MAIDEN NAME FIRST: Margaret MIDDLE: LAST: Barry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT: Kathleen Annarella ADDRESS: 6108 Overlea Road / Bethesda, MD. 20816

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration pneumonia	3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Cerebrovascular accident	4 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized atherosclerosis, coronary artery disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from 1-17, 1987, to 2-20, 1987, that ~~I~~ (we) last saw the deceased alive on 2-20, 1987, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~ did not) view the body after death.

22b. SIGNATURE: Joseph A. Romeo M.D. DEGREE: for ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/21/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH A. ROMEO

22e. ADDRESS: 10401 Old Georgetown Rd. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 2-21-87

23c. NAME OF CEMETERY OR CREMATORY: Georgetown Med School

23d. LOCATION CITY OR TOWN: Washington COUNTY: STATE: D.C.

24. FUNERAL DIRECTOR NAME: COLUMBIA MORTUARY SERVICES ADDRESS: 225 MISSOURI AVE, NW WASHINGTON, D.C. 20011

25a. DATE REC'D. BY REGISTRAR: FEB 25 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

045390 FEB 27 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 / 054 53
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Henry MIDDLE LAST Krause Jr.

2a. DATE OF DEATH: MONTH 2 DAY 20 YEAR 87

2b. HOUR 3:40 AM

3. SEX: M

4. RACE: white

5. DATE OF BIRTH: MONTH 8 DAY 28 YEAR 13

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): sales manager

12b. KIND OF BUSINESS OR INDUSTRY: private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince George

13c. CITY OR TOWN: Beltsville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 5213 Cochran Rd. 20705

14. FATHER'S NAME: FIRST Henry MIDDLE LAST Krause, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Margaret MIDDLE LAST Carr

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 498-05-3018

17. INFORMANT: Hazel S. Krause ADDRESS: same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTROPHIC + DILATED CARDIOMYOPATHY

DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Widely Metastatic Squamous cell Pulmonary Neoplasm

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 19 85 to Present 19 ____, that (I) (we) last saw the deceased alive on 2/19 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Norton Elson DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): NORTON ELSON

22e. ADDRESS: 6525 Belcrest Rd Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/21/87

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan

23d. LOCATION (CITY OR TOWN): Alexandria Fairfax Virginia

24. FUNERAL DIRECTOR: Donald V. Borgwardt ADDRESS: 4400 Powder Mill Rd. Beltsville Md 20705

25a. DATE REC'D. BY REGISTRAR: FEB 24 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84 (VRA 15, 4)

045032 FEB 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The other remaining carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified. In traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 054 54

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: STUART — MIDDLE: B — LAST: LAMB

2a. DATE OF DEATH — MONTH: 2 — DAY: 18 — YEAR: 87

2b. HOUR: 12 00 P.M.

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH — MONTH: 4 — DAY: 4 — YEAR: 09

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: TAKOMA PARK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HERITAGE HEALTH CARE CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): INSURANCE AGENT

12b. KIND OF BUSINESS OR INDUSTRY: INSURANCE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: MONT.

13c. CITY OR TOWN: TAKOMA PARK

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 123 GRANT AVENUE 20912

14. FATHER'S NAME — FIRST: PETER — MIDDLE: S. — LAST: LAMB

15. MOTHER'S MAIDEN NAME — FIRST: RADIE — MIDDLE: V. — LAST: MALCOLM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-01-4720A

17. INFORMANT: FRANCES R. LAMB — ADDRESS: 123 GRANT AVE. TAK. PK MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST.

DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL VASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, RENAL INSUFFICIENCY, DIABETIC RETINOPATHY

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6, 19 85, to 2/18, 19 87, that (I) (we) last saw the deceased alive on 2/13, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan Diamond.

DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN DIAMOND

22e. ADDRESS: 1106 SPRING ST, SILVER SPRING MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: FEB. 21. 1987

23c. NAME OF CEMETERY OR CREMATORY: St. John's Church Cemetery

23d. LOCATION — CITY OR TOWN: Forest Glen — COUNTY — STATE: MD

24. FUNERAL DIRECTOR — NAME: Takoma Funeral Home, Inc. — ADDRESS: 254 Carroll Ave NW DC

25a. DATE RECEIVED BY REGISTRAR: FEB 20 1987

REGISTRAR'S SIGNATURE: Julia Davidson-Reddick

044178 FEB 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 05455

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST JACK MIDDLE LAST LASOVER

2a. DATE OF DEATH: MONTH 2 DAY 10 YEAR 87

2b. HOUR: 2 A.M.

3. SEX: male

4. RACE: White

5. DATE OF BIRTH: MONTH 2 DAY 22 YEAR 07

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Kensington

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kensington Parden Nsg Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Gen. Acct Afsn

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY: ---------

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 400 Constitution Ave., N.E. - 20002

14. FATHER'S NAME: FIRST Morris MIDDLE LAST Lasover

15. MOTHER'S MAIDEN NAME: FIRST Fanny MIDDLE LAST Skolkin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 578-03-8448

17. INFORMANT: Frances Sherman; Niece; 3347 Hewitt Ave., #203; ADDRESS: Wheaton, Maryland 20906

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 75, to Prescut, 19 87, that (I) (we) last saw the deceased alive on Feb. 6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Merendino DEGREE: MD. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Feb. 10, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN MERENDINO, M.D.

22e. ADDRESS: 3347 Randolph Road; Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL: Burial

23b. DATE: 2/12/87

23c. NAME OF CEMETERY OR CREMATORY: Ohel Yakov Cong. Cemetery

23d. LOCATION: CITY OR TOWN Baltimore, Maryland COUNTY STATE

24. FUNERAL DIRECTOR: NAME DANZANSKY-GOLDBERG MEM. CHPLS. ADDRESS 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 13 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

044588 FEB 12

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 05456

1. DECEASED NAME (TYPE OR PRINT) FIRST: Annette MIDDLE: Joyce LAST: Lauer		2a. DATE OF DEATH MONTH DAY YEAR: February 14, 1987	2b. HOUR: 12:20 am
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: July 6, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5116 Fairglen Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookbinder	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Chevy Chase	YES ☐ NO ☒	5116 Fairglen Lane/20815

14. FATHER'S NAME FIRST / MIDDLE / LAST: John Joyce		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Mary Lukashevich	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 340-10-8027	17. INFORMANT: Loretta E. Strizak — ADDRESS: 883 Woodfield Rd. Franklin Lakes, NJ 07417

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma Left Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from July, 1985, to 14 Feb, 1987, that (I) (we) last saw the deceased alive on 12 Feb, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Wesley King MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: February 14, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Wesley King, M.D.	22e. ADDRESS: Pulmonary Division, Naval Hospital, Bethesda, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 18, 1987	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington 20814 Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. Bethesda, Maryland.		25a. DATE REC'D BY REGISTRAR: FEB 18 1987	25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

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